

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08056

FOR STATE  
HEALTH DEPT.

8104

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>5 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12603 Conn Ave</u>		d. STREET ADDRESS <u>12603 Conn Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Milton Abramowitz</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-15</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mathematician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. J. Standards</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Philip Abramowitz</u>		14. MOTHER'S MAIDEN NAME <u>Rose Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lillian Abramowitz (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>stroke</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>0</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brooklyn, N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. N. Gansky &amp; Sons</u>		ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	
DATE <u>JUL 11 '58</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

NEW YORK AND STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEPARTMENT OF HEALTH

PLACE ON DEATH  
CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8105

## CERTIFICATE OF DEATH

Reg. Dist. No.

08058

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda, Md.</u>			d. STREET ADDRESS <u>2322 South Arlington Ridge Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Ann</u> Last <u>Alisau</u>			4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 6, 1907</u>		9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Audit Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John T. Alisau</u>			14. MOTHER'S MAIDEN NAME <u>Vincenta Stackey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>057-09-1185</u>	17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>170 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Breast Carcinoma with wide spread metastases</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 Minutes</u> <u>4 1/2 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-pneumonia, pyelonephritis</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>April 11, 1958</u> , to <u>July 5, 1958</u> , that I last saw the deceased alive on <u>July 5, 1958</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James A. Rose</u>		M.D. <u>The Clinical Center</u>		ADDRESS (Street, city or town, state) <u>National Institutes of Health Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROSE, M.D.</u>				DATE SIGNED <u>7/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/9/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queen's Co. New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wisc. Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8106

## CERTIFICATE OF DEATH

Reg. Dist. No. 08057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>None</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 27, 16 x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5426 V Street-S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth F. Anderson</u>		4. DATE OF DEATH <u>7 23 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWAT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>FENTON Ridgeway</u>		14. MOTHER'S MAIDEN NAME <u>Laura Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Florence C Ridgeway Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X Pulmonary Infarction</u> DUE TO (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Right Auricular Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infarction Right</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-22</u> , 19 <u>58</u> , to <u>7-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-23</u> , 19 <u>58</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Hall</u>		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville Md.</u> DATE SIGNED <u>7-24-58</u>	
PHYSICIAN'S NAME (Type) <u>William G HALL</u>		<u>615 W. Montgomery Ave. Rockville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>July 28, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>577 11th St., S.E., Wash., D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Name of physician	
9. Name of informant		10. Signature of informant		11. Signature of physician		12. Signature of registrar	
13. Name of hospital		14. Name of attending physician		15. Name of funeral home		16. Name of cemetery	
17. Name of next of kin		18. Name of executor		19. Name of administrator		20. Name of guardian	
21. Name of trustee		22. Name of beneficiary		23. Name of heir		24. Name of legatee	
25. Name of devisee		26. Name of remainderman		27. Name of life tenant		28. Name of reversioner	
29. Name of remainderman		30. Name of life tenant		31. Name of reversioner		32. Name of devisee	
33. Name of legatee		34. Name of heir		35. Name of trustee		36. Name of beneficiary	
37. Name of heir		38. Name of trustee		39. Name of beneficiary		40. Name of devisee	
41. Name of devisee		42. Name of remainderman		43. Name of life tenant		44. Name of reversioner	
45. Name of remainderman		46. Name of life tenant		47. Name of reversioner		48. Name of devisee	
49. Name of legatee		50. Name of heir		51. Name of trustee		52. Name of beneficiary	
53. Name of heir		54. Name of trustee		55. Name of beneficiary		56. Name of devisee	
57. Name of devisee		58. Name of remainderman		59. Name of life tenant		60. Name of reversioner	
61. Name of remainderman		62. Name of life tenant		63. Name of reversioner		64. Name of devisee	
65. Name of legatee		66. Name of heir		67. Name of trustee		68. Name of beneficiary	
69. Name of heir		70. Name of trustee		71. Name of beneficiary		72. Name of devisee	
73. Name of devisee		74. Name of remainderman		75. Name of life tenant		76. Name of reversioner	
77. Name of remainderman		78. Name of life tenant		79. Name of reversioner		80. Name of devisee	
81. Name of legatee		82. Name of heir		83. Name of trustee		84. Name of beneficiary	
85. Name of heir		86. Name of trustee		87. Name of beneficiary		88. Name of devisee	
89. Name of devisee		90. Name of remainderman		91. Name of life tenant		92. Name of reversioner	
93. Name of remainderman		94. Name of life tenant		95. Name of reversioner		96. Name of devisee	
97. Name of legatee		98. Name of heir		99. Name of trustee		100. Name of beneficiary	

8107

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,011 REDDICK DRIVE</b>		d. STREET ADDRESS <b>/ 10,011 REDDICK DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>DAVIS</b> Last <b>BARBER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/17/81</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Black Jack, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN A. FRANKLIN</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Arthur D. Cashell, 10,011 Reddick Drive Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Coronary Occlusion</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/1/58</b> , 19 <b>58</b> , to <b>7/31/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/31/58</b> , 19 <b>58</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>		DATE SIGNED <b>8/1/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	22d. LOCATION (City, town, county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>AUG 4 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Reed Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**8108**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**08060**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b> <i>13x-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. Co. Gen. Hosp</b>		d. STREET ADDRESS <b>Limekilm Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Franklin Edgar Bassler</b>		4. DATE OF DEATH <b>July 26, 1958</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1/18/1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Bassler</b>	
14. MOTHER'S MAIDEN NAME <b>Lara Heiber</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Grace F. Bassler (wife)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Fulton</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/26/58</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Paul Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Fulton, Md</b>		22e. (State) <b>Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Canaldson, Laurel, Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>		24c. DATE	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IDENTIFICATION

John Oliver

John O. Oliver

John Oliver

John Oliver

John Oliver

John Oliver

John Oliver

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John Oliver

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8058

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San. and Hosp.</b>		d. STREET ADDRESS <b>1226 Woodside Pky.</b>	
3. NAME OF DECEASED (Type or print) <b>Marie</b>		4. DATE OF DEATH <b>July 10, 1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/75</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Scheu</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hosp. Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest during surgery</b> <b>903.0</b> DUE TO (b) <b>Ventricular Arrhythmia</b> Conditions, if any, which gave rise to immediate cause (c) <b>myocardial Ischemia + mucoid destruction of heart</b> gave rise to the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on bed room floor</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:50 a.m. 7-6 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Silver Spring Montg Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brosch</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>July 11-1958</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Hawker's Sons, Inc.</b>		24a. REC'D BY REGISTRAR <b>JUL 14 58</b>	
ADDRESS <b>1706 Pa. Ave. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Seach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.  
M

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON  
MAY 1 1935

REPORT OF PHYSICIAN  
Name of Patient: [illegible]  
Age: [illegible] Sex: [illegible]  
Address: [illegible]  
Date of Birth: [illegible]  
Date of Admission: [illegible]  
Date of Discharge: [illegible]  
Diagnosis: [illegible]  
Treatment: [illegible]  
Prognosis: [illegible]  
Remarks: [illegible]  
Physician's Signature: [illegible]  
Hospital Seal: [illegible]

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8109

CERTIFICATE OF DEATH

08062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4818 Earlston Drive</b>				d. STREET ADDRESS <b>4818 Earlston Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Ida</b> Last <b>Benner</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1958</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-1892</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick A. Knott</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lou Hurley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles J. Benner</b>		Address <b>4818 Earlston Drive Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b>August</b> Day <b>12</b> Year <b>1958</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1954</b> to <b>July 12, 1958</b> , that I last saw the deceased alive on <b>July 12, 1958</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elaine W. Murphy, M.D.</b>		ADDRESS (Street, city or town, state) <b>4812 Ellicott St. N.W., Wash. D.C.</b>		DATE SIGNED <b>7-12-58</b>			
PHYSICIAN'S NAME (Type) <b>ELAINE W. MURPHY, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arb. Smith</b>	

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1103

DATE OF DEATH

DECEASED

RESIDENCE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

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PLACE OF DEATH

Reg. Dist. No. 08063

<b>1. PLACE OF DEATH</b> a. COUNTY <div style="text-align: center; font-size: 1.2em;">Montgomery</div>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Redland</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">New Market</div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div style="text-align: center; font-size: 1.2em;">Ammons' Rest Home</div>		d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">108-2</div>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-size: 1.2em;">Abrahamm</div>		<b>4. DATE OF DEATH</b> Month      Day      Year <div style="text-align: center; font-size: 1.2em;">July      1      1958</div>	
<b>5. SEX</b> <div style="text-align: center; font-size: 1.2em;">Male</div>	<b>6. COLOR OR RACE</b> <div style="text-align: center; font-size: 1.2em;">Colored</div>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="text-align: center; font-size: 1.2em;">March 14, 1867</div>
<b>9. AGE</b> (In years last birthday) yrs. <div style="text-align: center; font-size: 1.2em;">91</div>		<b>10. IF UNDER 1 YEAR</b> Months      Days      Hours      Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Laborer</div>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <div style="text-align: center; font-size: 1.2em;">Maryland.</div>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center; font-size: 1.2em;">U.S. A.</div>	
<b>13. FATHER'S NAME</b> <div style="text-align: center; font-size: 1.2em;">Unknown</div>		<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center; font-size: 1.2em;">Emily Young</div>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)      (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <div style="text-align: center; font-size: 1.2em;">Mrs Annie Fawcett, New Market, Md.</div>		<b>18. INTERVAL BETWEEN ONSET AND DEATH</b> <div style="text-align: center; font-size: 1.2em;">3 days</div>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  IMMEDIATE CAUSE (a) <div style="text-align: center; font-size: 1.2em;">Cerebral Thrombosis</div>  442X DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {  (b) <div style="text-align: center; font-size: 1.2em;">Hypertensive C.R.Disease</div>  DUE TO  (c) <div style="text-align: center; font-size: 1.2em;">Arteriosclerosis</div> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <div style="text-align: center; font-size: 1.2em;">3 days</div> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <div style="text-align: center; font-size: 1.2em;">Arthritis.</div>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m.      p. m.      19	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that I attended the deceased from <div style="text-align: center; font-size: 1.2em;">June</div> , 1958, to <div style="text-align: center; font-size: 1.2em;">July 1</div> , 1958, that I last saw the deceased alive on <div style="text-align: center; font-size: 1.2em;">July 1</div> , 1958, and that death occurred at <div style="text-align: center; font-size: 1.2em;">6:10AM</div> , from the causes and on the date stated above <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>ACTUAL SIGNATURE</b>  <div style="text-align: center; font-size: 1.2em;">Webster Sewell</div> </div> <div style="width: 40%;"> <b>ADDRESS</b> (Street, city or town, state)  <div style="text-align: center; font-size: 1.2em;">Silver Spring, Md.</div> </div> </div>			
<b>PHYSICIAN'S NAME</b> (Type) <div style="text-align: center; font-size: 1.2em;">Webster Sewell</div>		<b>DATE SIGNED</b> <div style="text-align: center; font-size: 1.2em;">7/3/58</div>	
<b>22a. BURIAL, CREMATION, BENEFIT</b> (Specify)	<b>22b. DATE THEREOF</b> <div style="text-align: center; font-size: 1.2em;">7/4/58</div>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center; font-size: 1.2em;">Bush Park,</div>	<b>22d. LOCATION</b> (City, town, or county) (State) <div style="text-align: center; font-size: 1.2em;">Cooksville, Md.</div>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.2em;">Robert L. Snowden</div>		<b>ADDRESS</b> <div style="text-align: center; font-size: 1.2em;">Rockville, Md.</div>	<b>24a. REC'D BY REGISTRAR</b> DATE <div style="text-align: center; font-size: 1.2em;">JUL 8 '58</div>
		<b>24b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.2em;">[Signature]</div>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		Male		45		1880		Baltimore, Md.		Physician		Married		Heart Disease		Home		10:00 AM		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF CITY		21. NAME OF STATE		22. NAME OF COUNTRY		23. NAME OF COUNTY		24. NAME OF DISTRICT	
St. Paul's Episcopal Church		St. Paul's Episcopal Church		10/15/1925		Rev. J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		Baltimore		Maryland		United States of America		Baltimore		Baltimore	

8111

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>151 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Utah</b> b. COUNTY <b>Salt Lake City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>81x 3</b> d. STREET ADDRESS <b>3913A South, 3200 West</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LaVell (None) Bennion</b>				4. DATE OF DEATH Month Day Year <b>July 29, 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 30, 1931</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Utah</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Iris B. Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Gerrard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic carcinoma</b> DUE TO (c) <b>Choriocarcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 min.</b> <b>8 months</b> <b>1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 28, 1958</b> to <b>July 29, 1958</b> , that I last saw the deceased alive on <b>July 29, 1958</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 7/30/58</b> <b>The National Institutes of Health Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Theodore L. Goodfriend, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Theodore L. Goodfriend, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>				22b. DATE THEREOF <b>7/30/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Valley Memorial</b>	
22d. LOCATION (City, town, or county) (State) <b>Granger Utah</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert. A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45	SEX Male	RACE White
DATE OF DEATH January 28, 1935		TIME OF DEATH 10:30 A.M.	PLACE OF DEATH Home	CITY Baltimore
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		
DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF DEATH Baltimore, Maryland		
SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		SIGNATURE OF REGISTRAR John A. Thompson		
DATE OF SIGNATURE January 28, 1935		DATE OF SIGNATURE January 28, 1935		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8112

## CERTIFICATE OF DEATH

08065

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 McComas Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>ADELE</b> Last <b>BERESFORD</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/24/81</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lansburgh's Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HORACE BROWN</b>		14. MOTHER'S MAIDEN NAME <b>OPHELIA STEWART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>292-10-5595</b>	
17. INFORMANT <b>Mrs. Charles W. Kohl, 2602 Dennis Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart FAILURE</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silver Spring, Md.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> yrs. <b>yr</b> yrs. <b>yr</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 15, 1950</b> , to <b>7/23/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/23/58</b> , 19 <b>58</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7/23/59</b> DATE SIGNED			
ACTUAL SIGNATURE <b>SAM ALLEN</b> PHYSICIAN'S NAME (Type) <b>SAM ALLEN, M.D.</b> <b>Kensington, Maryland</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 28 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>

CERTIFICATE OF DEATH

FILE

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8113

## CERTIFICATE OF DEATH

08066  
Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>PK.</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>29 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>BERNARD</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 Nov. 1894</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Confidential Clerk, New Zealand Embassy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Howard BERNARD</b>				14. MOTHER'S MAIDEN NAME <b>Lillian OSWILL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW-I</b>		17. INFORMANT <b>(Wife) Mrs. Lucy Mary Bernard (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, Epidermoid type</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 June</b> , 19 <b>58</b> , to <b>28 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>26 July</b> , 19 <b>58</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerome A. Gold</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-28-58</b>			
PHYSICIAN'S NAME (Type) <b>Jerome A. Gold, LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-30-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers co.</b> ADDRESS <b>Chambers, 517 11th St., S.E. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Q. L. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8059 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		d. STREET ADDRESS <i>574 Southmontain Dr</i>	
3. NAME OF DECEASED (Type or print) <i>Maxine</i> First <i>Yellen</i> Middle <i>Besausky</i> Last		4. DATE OF DEATH <i>July 15- 1958</i> Month <i>July</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 28-1944</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School student</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Jack Besausky</i>		14. MOTHER'S MAIDEN NAME <i>Novelyn FENSTER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Arthur Shatzow</i> Address <i>Silver Spring</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>204.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute lymphatic leukemia</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1958</i> , to <i>July 15, 1958</i> , that I last saw the deceased alive on <i>July 14, 1958</i> , and that death occurred at <i>4:08 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward Adelson</i> M.D.		ADDRESS (Street, city or town, state) <i>1302 18th ST. N.W. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>EDWARD ADELSON</i>		DATE SIGNED <i>7/15/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7/17-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Falls Church Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i> ADDRESS <i>Wash. DC</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 19 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Adelson</i>

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8114

Item 7 Film 232 8-6-58 et

CERTIFICATE OF DEATH

08068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3910 Livingston St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>F</u> Middle <u>Bittinger</u> Last				4. DATE OF DEATH <u>July 31</u> 19 <u>58</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-73</u>	
9. AGE (In years, last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Heishear</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Donald S. Bittinger</u> Address <u>Son</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO (b) <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>58</u> , to <u>July 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>58</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantrant</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantrant MD</u>				DATE SIGNED <u>7/31/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.-</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ROBERT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8115

## CERTIFICATE OF DEATH

08069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Shenandoah</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Brent</b> Middle <b>Taylor</b> Last <b>Bly</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 September 1957</b>	
9. AGE (In years last birthday) <b>9</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minor Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Mr. Bobby W. Bly</b>				14. MOTHER'S MAIDEN NAME <b>Gladys Spiker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>756.2</b> <i>Grand pneumonia due to Staphylococcus</i> DUE TO (b) <i>Cytic fibrosis of pancreas</i> DUE TO (c) <i>from birth</i> INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 28</b> , <b>1958</b> , to <b>July 14</b> , <b>1958</b> , that I last saw the deceased alive on <b>July 14</b> , <b>1958</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <i>Charles B. Neal</i> M.D.				DATE SIGNED <b>7/14/58</b>			
PHYSICIAN'S NAME (Type) <b>Charles B. Neal, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lebanon Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Lebanon, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 16 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

9V VVVVVV XVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08070

8060

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY <u>47X-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				d. STREET ADDRESS <u>7924 Orchid St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>(nmn)</u> Last <u>Bobb</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-98</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Isaac Bobb</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (unknown) Salkind</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Ida Bobb</u>		Address <u>7924 Orchid St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Myocardium</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/15</u> , 19 <u>58</u> , to <u>7/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>58</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>				ADDRESS (Street, city or town, state) <u>7733 Alaska Ave. N.W. Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson</u>				DATE SIGNED <u>7/19/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kargansky &amp; Sons</u>				ADDRESS <u>3501-14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

CERTIFICATE OF DEATH

2000

Page One of Two

DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
DATE OF BIRTH		PLACE OF BIRTH	
PARENTS		SIBLINGS	
SPOUSE		CHILDREN	
GRANDCHILDREN		OTHER RELATIVES	
FAMILY HISTORY		SOCIAL HISTORY	
MEDICAL HISTORY		SURGICAL HISTORY	
HISTORICAL DATA		LABORATORY DATA	
PATHOLOGICAL DATA		RADIOLOGICAL DATA	
TREATMENT		PROGNOSIS	
FOLLOW-UP		REMARKS	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY CLERK, BALTIMORE, MARYLAND, FOR THE PURPOSE OF STATISTICAL RECORDS.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08071

Reg. Dist. No.

8116

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4112 Franklin Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lawrence</u> Last <u>Bockovac</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 24 HRS. Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Lawrence Bockovac</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-46-8176</u>		17. INFORMANT (Wife) <u>Mrs. Eva Bockovac</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Early Myocardial Infarction</u> DUE TO <u>Coronary Atherosclerosis, Marked</u> (b) <u>Acute Tracheo-bronchitis</u> DUE TO <u>Pulmonary atelectasis</u> (c) <u></u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 days</u> <u>24 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jul 21-58</u> , 19 <u>58</u> , to <u>Jul 23-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jul 23-58</u> , 19 <u>58</u> , and that death occurred at <u>3:40 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.				ADDRESS (Street, city or town, state) <u>10609 Concord St. Kensington, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>				DATE SIGNED <u>Jul 23, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	
22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Date of registration	
Robert C. Thompson, M.D.		Male		7/25/55		7/25/55		10:30 AM		Baltimore, Md.		Heart disease - coronary artery disease		Natural		Robert C. Thompson, M.D.		John A. Smith		7/25/55	
12. Name of informant		13. Relationship		14. Address		15. City		16. State		17. Zip		18. Signature of informant		19. Date of registration		20. Signature of registrar		21. Date of registration		22. Signature of registrar	
Mary Thompson		Wife		1234 Main St.		Baltimore		Md.		21201		Mary Thompson		7/25/55		John A. Smith		7/25/55		John A. Smith	

8061

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen &amp; Hospital</u>		e. STREET ADDRESS <u>11910 Andrew St</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Bomgardner</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-05</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Hogan</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mc Ginn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Husband</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Transverse Colon with metastasis to Liver</u> 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>58</u> to <u>July 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>58</u> , and that death occurred at <u>539</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u>		ADDRESS (Street, city or town, state) <u>8801 Coleville Road, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		DATE SIGNED <u>7/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/16/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>	22d. LOCATION (City, town, or county) (State) <u>Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Huntman &amp; Son</u>		24a. REC'D BY REGISTRAR <u>Am</u>	
ADDRESS <u>5751 Pa</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	
DATE <u>JUL 15 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08073

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3506 East West Hwy</u>			d. STREET ADDRESS <u>3506 East West Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>James Joseph Bowe</u>			4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-95</u>	9. AGE (In years and birthday) <u>63 yrs</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eng. Navy Dept</u>		11. BIRTHPLACE (State or foreign country) <u>N. H.</u>	
13. FATHER'S NAME <u>Andrew Bowe</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <u>WW 2</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
16. SOCIAL SECURITY NO. <u>577-40-4845</u>			17. INFORMANT <u>Donald Bowe (son)</u> Address <u>10407 Proctor Ave, Silver Spring, md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-15-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>10-15-58</i>	PLACE OF DEATH <i>Home</i>
AGE <i>45</i>		SEX <i>Male</i>	RACE <i>White</i>
MARRIED <i>Yes</i>		OCCUPATION <i>Teacher</i>	
EDUCATION <i>High School</i>		RELIGION <i>Catholic</i>	
BIRTH DATE <i>10-15-13</i>		BIRTH PLACE <i>Maryland</i>	
FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>Jane Doe</i>	
PREVIOUS ILLNESS <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		SIGNATURE OF EXAMINER <i>[Signature]</i>	
DATE OF EXAMINATION <i>10-15-58</i>		TIME OF EXAMINATION <i>10:00 AM</i>	
PLACE OF EXAMINATION <i>Home</i>		WITNESSES <i>[Signatures]</i>	
FAMILY HISTORY <i>None</i>		SOCIAL HISTORY <i>None</i>	
LABORATORY TESTS <i>None</i>		X-RAY <i>None</i>	
AUTOPSY <i>None</i>		OTHER <i>None</i>	

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8062

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>				d. STREET ADDRESS <u>2012 Somerset ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rheymond</u> Middle <u>Randolph</u> Last <u>Boyd</u>				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-17-17</u>	
				9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>40</u> Days <u>40</u> Hours <u>40</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engraving &amp; Printing, U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edgar R Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Pritchard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>St.</u> Mrs. Alice M. Boyd, 2012 Somerset St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>411X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease and</u> DUE TO (c) <u>Acute Insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FLANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-28-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 30 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8118

CERTIFICATE OF DEATH

08075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Rest Home</b>		e. STREET ADDRESS <b>29 W. Kirk Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>KATIE M BRANSON</b>		4. DATE OF DEATH <b>July 23, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1867</b>
9. AGE (In years last birthday) <b>91</b>		10. IF UNDER 1 YEAR <b>0</b> Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John N. Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn M. Goodrich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Geo. Vass-2022 Colorado Rd. N. W.</b>		Address <b>daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1950</b> to <b>July 23, 1958</b> , that I last saw the deceased alive on <b>July 20, 1958</b> , and that death occurred at <b>4:27 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Edgar E. Quayle</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Edgar E. Quayle</b>		<b>1822 Biltmore Street, N. W.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUL 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

# CERTIFICATE OF DEATH

8118

10-11-19

1. Name of deceased: JOHN A. MICHELL

2. Date of death: July 24, 1919

3. Place of death: Home

4. Age at death: 38

5. Sex: Male

6. Race: White

7. Marital status: Married

8. Cause of death: Heart disease

9. Date of burial: July 26, 1919

10. Place of burial: St. Mary's Cemetery

11. Name of funeral home: St. Mary's

12. Name of priest: Rev. J. J. O'Connell

13. Name of minister: Rev. J. J. O'Connell

14. Name of rabbi: Rev. J. J. O'Connell

15. Name of other religious leader: Rev. J. J. O'Connell

16. Name of physician: Dr. J. J. O'Connell

17. Name of coroner: Dr. J. J. O'Connell

18. Name of undertaker: Dr. J. J. O'Connell

19. Name of registrar: Dr. J. J. O'Connell

20. Name of other official: Dr. J. J. O'Connell

21. Name of other official: Dr. J. J. O'Connell

22. Name of other official: Dr. J. J. O'Connell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8119

## CERTIFICATE OF DEATH

Reg. Dist. No.

08076

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>78 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Park Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Benjamin</b> Last <b>Briggs</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen'l. and Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Gaithersburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wesley Briggs</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Sparrow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-36-6693</b>	
17. INFORMANT <b>Leila Heim Briggs</b>		Address <b>14 Park Ave., Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Mellitus</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1953, to <b>July 14, 1958</b> , that I last saw the deceased alive on <b>July 16, 1958</b> , and that death occurred at <b>11:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>F. J. Broschart</b> M.D. <b>Gaithersburg Md 7-11-58</b> PHYSICIAN'S NAME (Type) <b>F. J. Broschart, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 15 '58</b>	
ADDRESS <b>316 Diamond Ave., Gaithersburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08077

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5502 8th Street N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>James A. Brinker</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/20</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph M. Brinker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Hession</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Evelyn Brinker</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>902.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>atelectasis lower lobes</u> (c) <u>transection spinal cord C2-T1 dislocation</u> cause lost. 17 days INTERVAL BETWEEN ONSET AND DEATH <u>Four days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell 12 feet from new building under construction</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:30</u> Hour <u>7:18</u> o. m. <u>1958</u>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building</u>		20f. (City or town) (County) (State) <u>Rockville, Montgomery, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				24a. REC'D BY REGISTRAR <u>4812 Gp. Ave N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Seaver</u>	
				DATE <u>JUL 31 '58</u>			

FOR STATE  
HEALTH DEPT.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH—BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: Robert M. Jones  
AGE: 37 SEX: M  
DATE OF DEATH: July 12, 1941  
PLACE OF DEATH: Home  
CAUSE OF DEATH: Heart failure  
DISEASE OR INJURY: Coronary artery disease  
MANNER OF DEATH: Natural  
SIGNATURE OF EXAMINER: Dr. J. H. Smith  
OFFICE OF EXAMINER: Birmingham, Ala.  
DATE OF EXAMINATION: July 12, 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08078

8121

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>--</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural ROCKVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WAVERLY SANITARIUM</b>		d. STREET ADDRESS <b>2915 Conn. Ave., N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GENEVIEVE BROWN</b>		4. DATE OF DEATH Month Day Year <b>JULY 12 19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Gov't. Clerk</b>	
13. FATHER'S NAME <b>Albertus McCreary</b>		14. MOTHER'S MAIDEN NAME <b>Emma Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-34-9780</b>	
17. INFORMANT <b>Mrs. Margaret Wilkerson</b>		Address <b>2915 Conn. Ave. NW Wash. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute congestive Heart Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary artery Heart Disease</b> (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Essential Hypertension, Cerebral infarcts</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 1948</b> , to <b>7/12 1958</b> , that I last saw the deceased alive on <b>7/12 1958</b> , and that death occurred at <b>5:03 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul R. Wilner</b>		DATE SIGNED <b>Shoreham Hotel, Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>PAUL R. WILNER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/15/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St., N.W. Washington, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES J. WILSON		M		45		1880		New York		New York		1925		New York		Heart Disease		J. J. Wilson		J. J. Wilson		1925	
13. Name of informant		14. Relationship		15. Name of registrar		16. Signature of registrar		17. Date of registration		18. Place of registration		19. Cause of death		20. Signature of physician		21. Signature of registrar		22. Date of registration		23. Place of registration		24. Cause of death	
J. J. Wilson		Son		J. J. Wilson		J. J. Wilson		1925		New York		Heart Disease		J. J. Wilson		J. J. Wilson		1925		New York		Heart Disease	

1006200

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8122

## CERTIFICATE OF DEATH

08079

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>3 Days</b>		d. STREET ADDRESS <b>3027 Hamilton Ave.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Hobson</b> Last <b>BRYAN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>22 Oct. 1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>26</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy (Retired)</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Winfield BRYAN</b>		14. MOTHER'S MAIDEN NAME <b>Anne ASKEW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal hemorrhage</b> DUE TO <b>Cirrhosis of the liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>23 July</b> 19 <b>58</b> , to <b>26 July</b> 19 <b>58</b> , that I last saw the deceased alive on <b>26 July</b> 19 <b>58</b> , and that death occurred at <b>5:45P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J E Mc Clenathan</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-28-58</b>	
PHYSICIAN'S NAME (Type) <b>J. E. MC CLENATHAN, CDR MC USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		24a. REC'D BY REGISTRAR <b>JUL 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>
ADDRESS <b>W.W. Chambers, 1400 Chapin St., N.W. Washington, D.C.</b>		DATE	

MEDICAL CERTIFICATION

51

I

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8123

## CERTIFICATE OF DEATH

08080

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>277 1/2 Bainbridge Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Edmund</b> Middle <b>Joseph</b> Last <b>Burke</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 15, 1939</b>
9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Burke</b>		14. MOTHER'S MAIDEN NAME <b>Maureen Mulloly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital Heart Disease - supraventricular</b> DUE TO <b>aortic stenosis, calcified aortic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>aneurysm of arch of aorta</b> DUE TO <b>Status: Immediate postoperative repair of defects</b> (c) <b>18 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		INTERVAL BETWEEN ONSET AND DEATH <b>18 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 6, 1958</b> , to <b>July 17, 1958</b> , that I last saw the deceased alive on <b>July 17, 1958</b> and that death occurred at <b>4:33 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert D. Bloodwell</b>		DATE SIGNED <b>7/18/58</b>	
PHYSICIAN'S NAME (Type) <b>Robert D. Bloodwell, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-22-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Raymond's</b>		22d. LOCATION (City, town, or county) (State) <b>Brandy N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas B. Hanlon</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 23 '58</b>	
ADDRESS <b>3831 GA. AVE NW</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Deane</b>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>JOHN J. SMITH</u></p>		<p>14. Address of informant: <u>NEW YORK</u></p>	
<p>15. Name of informant: <u>JOHN J. SMITH</u></p>		<p>16. Address of informant: <u>NEW YORK</u></p>	
<p>17. Name of informant: <u>JOHN J. SMITH</u></p>		<p>18. Address of informant: <u>NEW YORK</u></p>	
<p>19. Name of informant: <u>JOHN J. SMITH</u></p>		<p>20. Address of informant: <u>NEW YORK</u></p>	
<p>21. Name of informant: <u>JOHN J. SMITH</u></p>		<p>22. Address of informant: <u>NEW YORK</u></p>	
<p>23. Name of informant: <u>JOHN J. SMITH</u></p>		<p>24. Address of informant: <u>NEW YORK</u></p>	
<p>25. Name of informant: <u>JOHN J. SMITH</u></p>		<p>26. Address of informant: <u>NEW YORK</u></p>	
<p>27. Name of informant: <u>JOHN J. SMITH</u></p>		<p>28. Address of informant: <u>NEW YORK</u></p>	
<p>29. Name of informant: <u>JOHN J. SMITH</u></p>		<p>30. Address of informant: <u>NEW YORK</u></p>	
<p>31. Name of informant: <u>JOHN J. SMITH</u></p>		<p>32. Address of informant: <u>NEW YORK</u></p>	
<p>33. Name of informant: <u>JOHN J. SMITH</u></p>		<p>34. Address of informant: <u>NEW YORK</u></p>	
<p>35. Name of informant: <u>JOHN J. SMITH</u></p>		<p>36. Address of informant: <u>NEW YORK</u></p>	
<p>37. Name of informant: <u>JOHN J. SMITH</u></p>		<p>38. Address of informant: <u>NEW YORK</u></p>	
<p>39. Name of informant: <u>JOHN J. SMITH</u></p>		<p>40. Address of informant: <u>NEW YORK</u></p>	
<p>41. Name of informant: <u>JOHN J. SMITH</u></p>		<p>42. Address of informant: <u>NEW YORK</u></p>	
<p>43. Name of informant: <u>JOHN J. SMITH</u></p>		<p>44. Address of informant: <u>NEW YORK</u></p>	
<p>45. Name of informant: <u>JOHN J. SMITH</u></p>		<p>46. Address of informant: <u>NEW YORK</u></p>	
<p>47. Name of informant: <u>JOHN J. SMITH</u></p>		<p>48. Address of informant: <u>NEW YORK</u></p>	
<p>49. Name of informant: <u>JOHN J. SMITH</u></p>		<p>50. Address of informant: <u>NEW YORK</u></p>	
<p>51. Name of informant: <u>JOHN J. SMITH</u></p>		<p>52. Address of informant: <u>NEW YORK</u></p>	
<p>53. Name of informant: <u>JOHN J. SMITH</u></p>		<p>54. Address of informant: <u>NEW YORK</u></p>	
<p>55. Name of informant: <u>JOHN J. SMITH</u></p>		<p>56. Address of informant: <u>NEW YORK</u></p>	
<p>57. Name of informant: <u>JOHN J. SMITH</u></p>		<p>58. Address of informant: <u>NEW YORK</u></p>	
<p>59. Name of informant: <u>JOHN J. SMITH</u></p>		<p>60. Address of informant: <u>NEW YORK</u></p>	
<p>61. Name of informant: <u>JOHN J. SMITH</u></p>		<p>62. Address of informant: <u>NEW YORK</u></p>	
<p>63. Name of informant: <u>JOHN J. SMITH</u></p>		<p>64. Address of informant: <u>NEW YORK</u></p>	
<p>65. Name of informant: <u>JOHN J. SMITH</u></p>		<p>66. Address of informant: <u>NEW YORK</u></p>	
<p>67. Name of informant: <u>JOHN J. SMITH</u></p>		<p>68. Address of informant: <u>NEW YORK</u></p>	
<p>69. Name of informant: <u>JOHN J. SMITH</u></p>		<p>70. Address of informant: <u>NEW YORK</u></p>	
<p>71. Name of informant: <u>JOHN J. SMITH</u></p>		<p>72. Address of informant: <u>NEW YORK</u></p>	
<p>73. Name of informant: <u>JOHN J. SMITH</u></p>		<p>74. Address of informant: <u>NEW YORK</u></p>	
<p>75. Name of informant: <u>JOHN J. SMITH</u></p>		<p>76. Address of informant: <u>NEW YORK</u></p>	
<p>77. Name of informant: <u>JOHN J. SMITH</u></p>		<p>78. Address of informant: <u>NEW YORK</u></p>	
<p>79. Name of informant: <u>JOHN J. SMITH</u></p>		<p>80. Address of informant: <u>NEW YORK</u></p>	
<p>81. Name of informant: <u>JOHN J. SMITH</u></p>		<p>82. Address of informant: <u>NEW YORK</u></p>	
<p>83. Name of informant: <u>JOHN J. SMITH</u></p>		<p>84. Address of informant: <u>NEW YORK</u></p>	
<p>85. Name of informant: <u>JOHN J. SMITH</u></p>		<p>86. Address of informant: <u>NEW YORK</u></p>	
<p>87. Name of informant: <u>JOHN J. SMITH</u></p>		<p>88. Address of informant: <u>NEW YORK</u></p>	
<p>89. Name of informant: <u>JOHN J. SMITH</u></p>		<p>90. Address of informant: <u>NEW YORK</u></p>	
<p>91. Name of informant: <u>JOHN J. SMITH</u></p>		<p>92. Address of informant: <u>NEW YORK</u></p>	
<p>93. Name of informant: <u>JOHN J. SMITH</u></p>		<p>94. Address of informant: <u>NEW YORK</u></p>	
<p>95. Name of informant: <u>JOHN J. SMITH</u></p>		<p>96. Address of informant: <u>NEW YORK</u></p>	
<p>97. Name of informant: <u>JOHN J. SMITH</u></p>		<p>98. Address of informant: <u>NEW YORK</u></p>	
<p>99. Name of informant: <u>JOHN J. SMITH</u></p>		<p>100. Address of informant: <u>NEW YORK</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08081

8124

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Dexter Ave</u>				d. STREET ADDRESS <u>1 2112 Dexter Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Mark</u> Last <u>Burns</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 11 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Elevator Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Burns</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>061-03-9648A</u>		17. INFORMANT <u>Mrs Sadie Burns</u> <u>2112 Dexter Ave Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repeated Cerebral hemorrhages</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. <u>  </u> p. <u>  </u> Month, <u>  </u> Day, <u>  </u> Year <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 8</u> , 19 <u>57</u> , to <u>July 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>58</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u>				M.D. <u>10110 Georgia Ave</u>		DATE SIGNED <u>7/6/58</u>	
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>				<u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8125

## CERTIFICATE OF DEATH

Reg. Dist. No.

08982.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Catherine</b> Last <b>CARMICHAEL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-29</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nathaniel WARNER</b>		14. MOTHER'S MAIDEN NAME <b>Maggie EVANS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Husband, Richard Louis Carmichael (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoma, Right Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 May</b> , 19 <b>58</b> , to <b>7 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7 July</b> , 19 <b>58</b> , and that death occurred at <b>11:50A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Larry J. Hines</b>		DATE SIGNED <b>7-7-58</b>	
PHYSICIAN'S NAME (Type) <b>LARRY J. HINES, LCDR MC USN</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moses Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bristol, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. P. Stewart</b>		ADDRESS <b>30 "H" St., N.E. Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>BUL 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reed</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md</b>		c. LENGTH OF STAY IN 1b <b>X Gaithersburg, Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Laytonsville</b>		e. STREET ADDRESS <b>Near Laytonsville</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Clyde Carter</b>		4. DATE OF DEATH Month <b>July</b> , Day <b>7</b> , Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/49</b>
9. AGE (In years last birthday) <b>8</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during months preceding life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Morris Carter</b>		14. MOTHER'S MAIDEN NAME <b>Celeste Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>914.5</b> DUE TO <b>Electrocution</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>914.5</b> DUE TO <b>Electrocution</b> (c) <b>914.5</b> DUE TO <b>Electrocution</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fence</b> <b>Apparently contacted live hanging while crossing</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:15 p.m. 7/7/58 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) (County) (State) <b>Laytonsville, Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7/7/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove.,</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. [unclear]</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[unclear]</b>	

RECEIVED  
JUL 10 1958

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW

MARLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19	
MISE MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Name: Robert Jayde Carter	
Age: 34	
Sex: Male	
Race: White	
Date of Birth: July 7, 1924	
Place of Birth: New Yorkville	
Residence: Baltimore, Md.	
Occupation: Doctor	
Cause of Death: Electrocution	
Manner of Death: Suicide	
Signature: [Signature]	
Date: July 10, 1958	

8127

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Beaufort</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>June</b> Middle <b>Matlow</b> Last <b>CHAMPION</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Maxillian MATLOW</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca MANN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>	
17. INFORMANT <b>(Husband) Carleton C. CHAMPION, Jr. (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO (c) <b>Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 July</b> , 19 <b>58</b> , to <b>27 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>27 July</b> , 19 <b>58</b> , and that death occurred at <b>1:42P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. C. Johnson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-28-58</b>	
PHYSICIAN'S NAME (Type) <b>B. C. JOHNSON, LCDR MC USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Adath Yeshurun Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Syracuse, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzanski &amp; Sons</b> <b>Danzanski, 3301 14th St., N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 '58</b> DATE REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8137

<p>1. NAME OF DECEASED                  JAMES EARL RAY</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  35 years</p>		<p>4. DATE OF BIRTH                  May 19, 1928</p>	
<p>5. PLACE OF BIRTH                  Jackson, Mississippi</p>		<p>6. OCCUPATION                  None</p>	
<p>7. MARITAL STATUS                  Single</p>		<p>8. COLOR                  White</p>	
<p>9. EDUCATION                  High School</p>		<p>10. RELIGION                  None</p>	
<p>11. PRESENT ADDRESS                  1000 North Broadway, Baltimore, Md.</p>		<p>12. DATE OF DEATH                  May 2, 1968</p>	
<p>13. PLACE OF DEATH                  Baltimore, Md.</p>		<p>14. CAUSE OF DEATH                  (a) Immediate Cause: Gunshot wound of the chest                  (b) Underlying Cause: Mental illness</p>	
<p>15. SIGNATURE OF PHYSICIAN                  [Signature]</p>		<p>16. SIGNATURE OF REGISTRAR                  [Signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8128

CERTIFICATE OF DEATH

08085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	c. LENGTH OF STAY IN 1b <b>9 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5506 Montgomery St.</b>		d. STREET ADDRESS <b>15506 Montgomery Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>CHAPPELEAR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Fed. Deposit Ins. Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Benjamin Franklin Chappellear</b>		14. MOTHER'S MAIDEN NAME <b>Anna Burch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>577-10-0472</b>	
17. INFORMANT <b>Daughter</b>		Address <b>Mrs. A. F. Keithley Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Carcinomatosis</b> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of rectum</b> DUE TO <b>and ascending colon</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan, 1953</b> , to <b>4 Jul, 1958</b> , that I last saw the deceased alive on <b>28 Jun, 1958</b> , and that death occurred at <b>15506 M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Warren B Burch</b> M.D.		ADDRESS (Street, city or town, state) <b>405 A Street, S. E.</b> DATE SIGNED <b>7-4-58</b>	
PHYSICIAN'S NAME (Type) <b>WARREN B. BURCH</b>		<b>Washington, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Burch</b>	



Items 16 & 17 Film G231 7/21/58

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Ohio</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>8996 Lynnhaven Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Carlos</b> Middle <b>Thulin</b> Last <b>Christensen</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1923</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing</b>	
11. BIRTHPLACE (State or foreign country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Neils M. Christensen</b>		14. MOTHER'S MAIDEN NAME <b>Andrea Thulin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>297-14-5778</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Duodenal Perforation</b> DUE TO (c) <b>Metastatic Embryonal Cell Ca of Testis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6, 1958</b> , to <b>July 16, 1958</b> , that I last saw the deceased alive on <b>July 16, 1958</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard H. Moy</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>7/16/58</b>	
PHYSICIAN'S NAME (Type) <b>Richard H. Moy, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>7-18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John Doe</u></p>	
<p>2. Date of Death: <u>10/15/1915</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>45</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Signature of Physician: <u>[Signature]</u></p>	
<p>9. Signature of Registrar: <u>[Signature]</u></p>	
<p>10. Date of Registration: <u>10/16/1915</u></p>	
<p>11. Place of Registration: <u>City of New York</u></p>	
<p>12. Name of Registrar: <u>John Smith</u></p>	
<p>13. Address of Registrar: <u>123 Main St.</u></p>	
<p>14. City: <u>New York</u></p>	
<p>15. State: <u>New York</u></p>	
<p>16. County: <u>New York</u></p>	
<p>17. District: <u>1st</u></p>	
<p>18. Ward: <u>1st</u></p>	
<p>19. Block: <u>1st</u></p>	
<p>20. Lot: <u>1st</u></p>	
<p>21. Sublot: <u>1st</u></p>	
<p>22. Section: <u>1st</u></p>	
<p>23. Township: <u>1st</u></p>	
<p>24. Range: <u>1st</u></p>	
<p>25. Meridian: <u>1st</u></p>	
<p>26. Township: <u>1st</u></p>	
<p>27. Range: <u>1st</u></p>	
<p>28. Meridian: <u>1st</u></p>	
<p>29. Township: <u>1st</u></p>	
<p>30. Range: <u>1st</u></p>	
<p>31. Meridian: <u>1st</u></p>	
<p>32. Township: <u>1st</u></p>	
<p>33. Range: <u>1st</u></p>	
<p>34. Meridian: <u>1st</u></p>	
<p>35. Township: <u>1st</u></p>	
<p>36. Range: <u>1st</u></p>	
<p>37. Meridian: <u>1st</u></p>	
<p>38. Township: <u>1st</u></p>	
<p>39. Range: <u>1st</u></p>	
<p>40. Meridian: <u>1st</u></p>	
<p>41. Township: <u>1st</u></p>	
<p>42. Range: <u>1st</u></p>	
<p>43. Meridian: <u>1st</u></p>	
<p>44. Township: <u>1st</u></p>	
<p>45. Range: <u>1st</u></p>	
<p>46. Meridian: <u>1st</u></p>	
<p>47. Township: <u>1st</u></p>	
<p>48. Range: <u>1st</u></p>	
<p>49. Meridian: <u>1st</u></p>	
<p>50. Township: <u>1st</u></p>	
<p>51. Range: <u>1st</u></p>	
<p>52. Meridian: <u>1st</u></p>	
<p>53. Township: <u>1st</u></p>	
<p>54. Range: <u>1st</u></p>	
<p>55. Meridian: <u>1st</u></p>	
<p>56. Township: <u>1st</u></p>	
<p>57. Range: <u>1st</u></p>	
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<p>60. Range: <u>1st</u></p>	
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<p>64. Meridian: <u>1st</u></p>	
<p>65. Township: <u>1st</u></p>	
<p>66. Range: <u>1st</u></p>	
<p>67. Meridian: <u>1st</u></p>	
<p>68. Township: <u>1st</u></p>	
<p>69. Range: <u>1st</u></p>	
<p>70. Meridian: <u>1st</u></p>	
<p>71. Township: <u>1st</u></p>	
<p>72. Range: <u>1st</u></p>	
<p>73. Meridian: <u>1st</u></p>	
<p>74. Township: <u>1st</u></p>	
<p>75. Range: <u>1st</u></p>	
<p>76. Meridian: <u>1st</u></p>	
<p>77. Township: <u>1st</u></p>	
<p>78. Range: <u>1st</u></p>	
<p>79. Meridian: <u>1st</u></p>	
<p>80. Township: <u>1st</u></p>	
<p>81. Range: <u>1st</u></p>	
<p>82. Meridian: <u>1st</u></p>	
<p>83. Township: <u>1st</u></p>	
<p>84. Range: <u>1st</u></p>	
<p>85. Meridian: <u>1st</u></p>	
<p>86. Township: <u>1st</u></p>	
<p>87. Range: <u>1st</u></p>	
<p>88. Meridian: <u>1st</u></p>	
<p>89. Township: <u>1st</u></p>	
<p>90. Range: <u>1st</u></p>	
<p>91. Meridian: <u>1st</u></p>	
<p>92. Township: <u>1st</u></p>	
<p>93. Range: <u>1st</u></p>	
<p>94. Meridian: <u>1st</u></p>	
<p>95. Township: <u>1st</u></p>	
<p>96. Range: <u>1st</u></p>	
<p>97. Meridian: <u>1st</u></p>	
<p>98. Township: <u>1st</u></p>	
<p>99. Range: <u>1st</u></p>	
<p>100. Meridian: <u>1st</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8130 CERTIFICATE OF DEATH

08087  
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>life</u> x <u>Poolesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Jerusalem Road</u>		d. STREET ADDRESS <u>Jerusalem Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Noah E. CLARK</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Clark</u>		14. MOTHER'S MAIDEN NAME <u>Leanna Worsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary E. Clarke</u>		Address <u>Poolesville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Carcinoma</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition, Cachexia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>28 March 1952</u> , to <u>July 7, 1958</u> , that I last saw the deceased alive on <u>5 July 1958</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box of Md</u> DATE SIGNED <u>7/9/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem</u>	22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snow</u>		ADDRESS <u>Poolesville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 16 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

CERTIFICATE OF DEATH

8252

<p>1. NAME OF DECEASED                  CLARK, John                  1874</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  51</p>		<p>4. DATE OF DEATH                  July 3, 1925</p>	
<p>5. PLACE OF DEATH                  1015 North Street                  Boston, Mass.</p>		<p>6. CAUSE OF DEATH                  Myocardial Infarction</p>	
<p>7. OCCASION OF DEATH                  Sudden</p>		<p>8. PLACE OF BIRTH                  Ireland</p>	
<p>9. DATE OF BIRTH                  July 18, 1874</p>		<p>10. PLACE OF BIRTH                  Ireland</p>	
<p>11. NAME OF PHYSICIAN                  Dr. J. H. Clark</p>		<p>12. NAME OF FUNERAL HOME                  J. H. Clark</p>	
<p>13. NAME OF BURIAL PLACE                  St. Patrick's Cemetery</p>		<p>14. NAME OF MINISTER                  Rev. J. H. Clark</p>	
<p>15. NAME OF WITNESS                  J. H. Clark</p>		<p>16. NAME OF WITNESS                  J. H. Clark</p>	
<p>17. NAME OF WITNESS                  J. H. Clark</p>		<p>18. NAME OF WITNESS                  J. H. Clark</p>	
<p>19. NAME OF WITNESS                  J. H. Clark</p>		<p>20. NAME OF WITNESS                  J. H. Clark</p>	
<p>21. NAME OF WITNESS                  J. H. Clark</p>		<p>22. NAME OF WITNESS                  J. H. Clark</p>	
<p>23. NAME OF WITNESS                  J. H. Clark</p>		<p>24. NAME OF WITNESS                  J. H. Clark</p>	
<p>25. NAME OF WITNESS                  J. H. Clark</p>		<p>26. NAME OF WITNESS                  J. H. Clark</p>	
<p>27. NAME OF WITNESS                  J. H. Clark</p>		<p>28. NAME OF WITNESS                  J. H. Clark</p>	
<p>29. NAME OF WITNESS                  J. H. Clark</p>		<p>30. NAME OF WITNESS                  J. H. Clark</p>	
<p>31. NAME OF WITNESS                  J. H. Clark</p>		<p>32. NAME OF WITNESS                  J. H. Clark</p>	
<p>33. NAME OF WITNESS                  J. H. Clark</p>		<p>34. NAME OF WITNESS                  J. H. Clark</p>	
<p>35. NAME OF WITNESS                  J. H. Clark</p>		<p>36. NAME OF WITNESS                  J. H. Clark</p>	
<p>37. NAME OF WITNESS                  J. H. Clark</p>		<p>38. NAME OF WITNESS                  J. H. Clark</p>	
<p>39. NAME OF WITNESS                  J. H. Clark</p>		<p>40. NAME OF WITNESS                  J. H. Clark</p>	
<p>41. NAME OF WITNESS                  J. H. Clark</p>		<p>42. NAME OF WITNESS                  J. H. Clark</p>	
<p>43. NAME OF WITNESS                  J. H. Clark</p>		<p>44. NAME OF WITNESS                  J. H. Clark</p>	
<p>45. NAME OF WITNESS                  J. H. Clark</p>		<p>46. NAME OF WITNESS                  J. H. Clark</p>	
<p>47. NAME OF WITNESS                  J. H. Clark</p>		<p>48. NAME OF WITNESS                  J. H. Clark</p>	
<p>49. NAME OF WITNESS                  J. H. Clark</p>		<p>50. NAME OF WITNESS                  J. H. Clark</p>	
<p>51. NAME OF WITNESS                  J. H. Clark</p>		<p>52. NAME OF WITNESS                  J. H. Clark</p>	
<p>53. NAME OF WITNESS                  J. H. Clark</p>		<p>54. NAME OF WITNESS                  J. H. Clark</p>	
<p>55. NAME OF WITNESS                  J. H. Clark</p>		<p>56. NAME OF WITNESS                  J. H. Clark</p>	
<p>57. NAME OF WITNESS                  J. H. Clark</p>		<p>58. NAME OF WITNESS                  J. H. Clark</p>	
<p>59. NAME OF WITNESS                  J. H. Clark</p>		<p>60. NAME OF WITNESS                  J. H. Clark</p>	
<p>61. NAME OF WITNESS                  J. H. Clark</p>		<p>62. NAME OF WITNESS                  J. H. Clark</p>	
<p>63. NAME OF WITNESS                  J. H. Clark</p>		<p>64. NAME OF WITNESS                  J. H. Clark</p>	
<p>65. NAME OF WITNESS                  J. H. Clark</p>		<p>66. NAME OF WITNESS                  J. H. Clark</p>	
<p>67. NAME OF WITNESS                  J. H. Clark</p>		<p>68. NAME OF WITNESS                  J. H. Clark</p>	
<p>69. NAME OF WITNESS                  J. H. Clark</p>		<p>70. NAME OF WITNESS                  J. H. Clark</p>	
<p>71. NAME OF WITNESS                  J. H. Clark</p>		<p>72. NAME OF WITNESS                  J. H. Clark</p>	
<p>73. NAME OF WITNESS                  J. H. Clark</p>		<p>74. NAME OF WITNESS                  J. H. Clark</p>	
<p>75. NAME OF WITNESS                  J. H. Clark</p>		<p>76. NAME OF WITNESS                  J. H. Clark</p>	
<p>77. NAME OF WITNESS                  J. H. Clark</p>		<p>78. NAME OF WITNESS                  J. H. Clark</p>	
<p>79. NAME OF WITNESS                  J. H. Clark</p>		<p>80. NAME OF WITNESS                  J. H. Clark</p>	
<p>81. NAME OF WITNESS                  J. H. Clark</p>		<p>82. NAME OF WITNESS                  J. H. Clark</p>	
<p>83. NAME OF WITNESS                  J. H. Clark</p>		<p>84. NAME OF WITNESS                  J. H. Clark</p>	
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<p>89. NAME OF WITNESS                  J. H. Clark</p>		<p>90. NAME OF WITNESS                  J. H. Clark</p>	
<p>91. NAME OF WITNESS                  J. H. Clark</p>		<p>92. NAME OF WITNESS                  J. H. Clark</p>	
<p>93. NAME OF WITNESS                  J. H. Clark</p>		<p>94. NAME OF WITNESS                  J. H. Clark</p>	
<p>95. NAME OF WITNESS                  J. H. Clark</p>		<p>96. NAME OF WITNESS                  J. H. Clark</p>	
<p>97. NAME OF WITNESS                  J. H. Clark</p>		<p>98. NAME OF WITNESS                  J. H. Clark</p>	
<p>99. NAME OF WITNESS                  J. H. Clark</p>		<p>100. NAME OF WITNESS                  J. H. Clark</p>	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08088

Reg. Dist. No.

Item 18 Film 232 8-11-58 am

8098

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>207 E. Argyle Ave., Apt. 8</b>		d. STREET ADDRESS <b>207 E. Argyle Ave., Apt. 8</b>	
3. NAME OF DECEASED (Type or print) <b>Michael Joseph Coady</b>		4. DATE OF DEATH <b>July 12, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/58</b>
9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER YEAR <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Coady</b>		14. MOTHER'S MAIDEN NAME <b>Caryl Breetborde</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonia, bilateral, severe</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral subperiosteal hematoma, organizing, Parietal bones</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 12, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elbert Gaithebury, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 16 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. Schuch</b>	

9V VV VV V XVV

STATE  
HEALTH DEPT

8998

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 30  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8063** **CERTIFICATE OF DEATH**

08089

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>one day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest GORDON XXXXXX</u> First Middle Last <u>Cogan</u>				4. DATE OF DEATH <u>July 23 1958</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>march 14, 1890</u>	9. AGE (In years lost birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Stand operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Lucian D. Cogan</u>				14. MOTHER'S MAIDEN NAME <u>Sonia Cogan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>214-03-8350</u>		17. INFORMANT <u>Mrs. Esther B. Cogan</u> Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Posterior Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>nephrosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1954</u> to <u>July 23, 1958</u> , that I last saw the deceased alive on <u>July 23, 1958</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.				ADDRESS (Street, city or town, state) <u>8801 Colesville Road, Silver Spring, Md.</u> DATE SIGNED <u>7/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8003

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH COUNTRY		8. MARRIAGE DATE		9. MARRIAGE PLACE		10. MARRIAGE COUNTRY	
11. OCCUPATION		12. CAUSE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. COUNTY		17. STATE		18. CITY		19. ZIP CODE		20. SIGNATURE	
21. MEDICAL HISTORY		22. PHYSICIAN'S SIGNATURE		23. PHYSICIAN'S TITLE		24. PHYSICIAN'S ADDRESS		25. PHYSICIAN'S PHONE		26. PHYSICIAN'S FAX		27. PHYSICIAN'S E-MAIL		28. PHYSICIAN'S LICENSE		29. PHYSICIAN'S BOARD		30. PHYSICIAN'S SPECIALTY	
31. NURSE'S SIGNATURE		32. NURSE'S TITLE		33. NURSE'S ADDRESS		34. NURSE'S PHONE		35. NURSE'S FAX		36. NURSE'S E-MAIL		37. NURSE'S LICENSE		38. NURSE'S BOARD		39. NURSE'S SPECIALTY		40. NURSE'S SIGNATURE	
41. CORONER'S SIGNATURE		42. CORONER'S TITLE		43. CORONER'S ADDRESS		44. CORONER'S PHONE		45. CORONER'S FAX		46. CORONER'S E-MAIL		47. CORONER'S LICENSE		48. CORONER'S BOARD		49. CORONER'S SPECIALTY		50. CORONER'S SIGNATURE	
51. JUDGE'S SIGNATURE		52. JUDGE'S TITLE		53. JUDGE'S ADDRESS		54. JUDGE'S PHONE		55. JUDGE'S FAX		56. JUDGE'S E-MAIL		57. JUDGE'S LICENSE		58. JUDGE'S BOARD		59. JUDGE'S SPECIALTY		60. JUDGE'S SIGNATURE	
61. DISTRICT ATTORNEY'S SIGNATURE		62. DISTRICT ATTORNEY'S TITLE		63. DISTRICT ATTORNEY'S ADDRESS		64. DISTRICT ATTORNEY'S PHONE		65. DISTRICT ATTORNEY'S FAX		66. DISTRICT ATTORNEY'S E-MAIL		67. DISTRICT ATTORNEY'S LICENSE		68. DISTRICT ATTORNEY'S BOARD		69. DISTRICT ATTORNEY'S SPECIALTY		70. DISTRICT ATTORNEY'S SIGNATURE	
71. COUNTY CLERK'S SIGNATURE		72. COUNTY CLERK'S TITLE		73. COUNTY CLERK'S ADDRESS		74. COUNTY CLERK'S PHONE		75. COUNTY CLERK'S FAX		76. COUNTY CLERK'S E-MAIL		77. COUNTY CLERK'S LICENSE		78. COUNTY CLERK'S BOARD		79. COUNTY CLERK'S SPECIALTY		80. COUNTY CLERK'S SIGNATURE	
81. VENDOR'S SIGNATURE		82. VENDOR'S TITLE		83. VENDOR'S ADDRESS		84. VENDOR'S PHONE		85. VENDOR'S FAX		86. VENDOR'S E-MAIL		87. VENDOR'S LICENSE		88. VENDOR'S BOARD		89. VENDOR'S SPECIALTY		90. VENDOR'S SIGNATURE	
91. WITNESS'S SIGNATURE		92. WITNESS'S TITLE		93. WITNESS'S ADDRESS		94. WITNESS'S PHONE		95. WITNESS'S FAX		96. WITNESS'S E-MAIL		97. WITNESS'S LICENSE		98. WITNESS'S BOARD		99. WITNESS'S SPECIALTY		100. WITNESS'S SIGNATURE	
101. JURY'S SIGNATURE		102. JURY'S TITLE		103. JURY'S ADDRESS		104. JURY'S PHONE		105. JURY'S FAX		106. JURY'S E-MAIL		107. JURY'S LICENSE		108. JURY'S BOARD		109. JURY'S SPECIALTY		110. JURY'S SIGNATURE	
111. JUDGE'S SIGNATURE		112. JUDGE'S TITLE		113. JUDGE'S ADDRESS		114. JUDGE'S PHONE		115. JUDGE'S FAX		116. JUDGE'S E-MAIL		117. JUDGE'S LICENSE		118. JUDGE'S BOARD		119. JUDGE'S SPECIALTY		120. JUDGE'S SIGNATURE	
121. DISTRICT ATTORNEY'S SIGNATURE		122. DISTRICT ATTORNEY'S TITLE		123. DISTRICT ATTORNEY'S ADDRESS		124. DISTRICT ATTORNEY'S PHONE		125. DISTRICT ATTORNEY'S FAX		126. DISTRICT ATTORNEY'S E-MAIL		127. DISTRICT ATTORNEY'S LICENSE		128. DISTRICT ATTORNEY'S BOARD		129. DISTRICT ATTORNEY'S SPECIALTY		130. DISTRICT ATTORNEY'S SIGNATURE	
131. COUNTY CLERK'S SIGNATURE		132. COUNTY CLERK'S TITLE		133. COUNTY CLERK'S ADDRESS		134. COUNTY CLERK'S PHONE		135. COUNTY CLERK'S FAX		136. COUNTY CLERK'S E-MAIL		137. COUNTY CLERK'S LICENSE		138. COUNTY CLERK'S BOARD		139. COUNTY CLERK'S SPECIALTY		140. COUNTY CLERK'S SIGNATURE	
141. VENDOR'S SIGNATURE		142. VENDOR'S TITLE		143. VENDOR'S ADDRESS		144. VENDOR'S PHONE		145. VENDOR'S FAX		146. VENDOR'S E-MAIL		147. VENDOR'S LICENSE		148. VENDOR'S BOARD		149. VENDOR'S SPECIALTY		150. VENDOR'S SIGNATURE	
151. WITNESS'S SIGNATURE		152. WITNESS'S TITLE		153. WITNESS'S ADDRESS		154. WITNESS'S PHONE		155. WITNESS'S FAX		156. WITNESS'S E-MAIL		157. WITNESS'S LICENSE		158. WITNESS'S BOARD		159. WITNESS'S SPECIALTY		160. WITNESS'S SIGNATURE	
161. JURY'S SIGNATURE		162. JURY'S TITLE		163. JURY'S ADDRESS		164. JURY'S PHONE		165. JURY'S FAX		166. JURY'S E-MAIL		167. JURY'S LICENSE		168. JURY'S BOARD		169. JURY'S SPECIALTY		170. JURY'S SIGNATURE	
171. JUDGE'S SIGNATURE		172. JUDGE'S TITLE		173. JUDGE'S ADDRESS		174. JUDGE'S PHONE		175. JUDGE'S FAX		176. JUDGE'S E-MAIL		177. JUDGE'S LICENSE		178. JUDGE'S BOARD		179. JUDGE'S SPECIALTY		180. JUDGE'S SIGNATURE	
181. DISTRICT ATTORNEY'S SIGNATURE		182. DISTRICT ATTORNEY'S TITLE		183. DISTRICT ATTORNEY'S ADDRESS		184. DISTRICT ATTORNEY'S PHONE		185. DISTRICT ATTORNEY'S FAX		186. DISTRICT ATTORNEY'S E-MAIL		187. DISTRICT ATTORNEY'S LICENSE		188. DISTRICT ATTORNEY'S BOARD		189. DISTRICT ATTORNEY'S SPECIALTY		190. DISTRICT ATTORNEY'S SIGNATURE	
191. COUNTY CLERK'S SIGNATURE		192. COUNTY CLERK'S TITLE		193. COUNTY CLERK'S ADDRESS		194. COUNTY CLERK'S PHONE		195. COUNTY CLERK'S FAX		196. COUNTY CLERK'S E-MAIL		197. COUNTY CLERK'S LICENSE		198. COUNTY CLERK'S BOARD		199. COUNTY CLERK'S SPECIALTY		200. COUNTY CLERK'S SIGNATURE	
201. VENDOR'S SIGNATURE		202. VENDOR'S TITLE		203. VENDOR'S ADDRESS		204. VENDOR'S PHONE		205. VENDOR'S FAX		206. VENDOR'S E-MAIL		207. VENDOR'S LICENSE		208. VENDOR'S BOARD		209. VENDOR'S SPECIALTY		210. VENDOR'S SIGNATURE	
211. WITNESS'S SIGNATURE		212. WITNESS'S TITLE		213. WITNESS'S ADDRESS		214. WITNESS'S PHONE		215. WITNESS'S FAX		216. WITNESS'S E-MAIL		217. WITNESS'S LICENSE		218. WITNESS'S BOARD		219. WITNESS'S SPECIALTY		220. WITNESS'S SIGNATURE	
221. JURY'S SIGNATURE		222. JURY'S TITLE		223. JURY'S ADDRESS		224. JURY'S PHONE		225. JURY'S FAX		226. JURY'S E-MAIL		227. JURY'S LICENSE		228. JURY'S BOARD		229. JURY'S SPECIALTY		230. JURY'S SIGNATURE	
231. JUDGE'S SIGNATURE		232. JUDGE'S TITLE		233. JUDGE'S ADDRESS		234. JUDGE'S PHONE		235. JUDGE'S FAX		236. JUDGE'S E-MAIL		237. JUDGE'S LICENSE		238. JUDGE'S BOARD		239. JUDGE'S SPECIALTY		240. JUDGE'S SIGNATURE	
241. DISTRICT ATTORNEY'S SIGNATURE		242. DISTRICT ATTORNEY'S TITLE		243. DISTRICT ATTORNEY'S ADDRESS		244. DISTRICT ATTORNEY'S PHONE		245. DISTRICT ATTORNEY'S FAX		246. DISTRICT ATTORNEY'S E-MAIL		247. DISTRICT ATTORNEY'S LICENSE		248. DISTRICT ATTORNEY'S BOARD		249. DISTRICT ATTORNEY'S SPECIALTY		250. DISTRICT ATTORNEY'S SIGNATURE	
251. COUNTY CLERK'S SIGNATURE		252. COUNTY CLERK'S TITLE		253. COUNTY CLERK'S ADDRESS		254. COUNTY CLERK'S PHONE		255. COUNTY CLERK'S FAX		256. COUNTY CLERK'S E-MAIL		257. COUNTY CLERK'S LICENSE		258. COUNTY CLERK'S BOARD		259. COUNTY CLERK'S SPECIALTY		260. COUNTY CLERK'S SIGNATURE	
261. VENDOR'S SIGNATURE		262. VENDOR'S TITLE		263. VENDOR'S ADDRESS		264. VENDOR'S PHONE		265. VENDOR'S FAX		266. VENDOR'S E-MAIL		267. VENDOR'S LICENSE		268. VENDOR'S BOARD		269. VENDOR'S SPECIALTY		270. VENDOR'S SIGNATURE	
271. WITNESS'S SIGNATURE		272. WITNESS'S TITLE		273. WITNESS'S ADDRESS		274. WITNESS'S PHONE		275. WITNESS'S FAX		276. WITNESS'S E-MAIL		277. WITNESS'S LICENSE		278. WITNESS'S BOARD		279. WITNESS'S SPECIALTY		280. WITNESS'S SIGNATURE	
281. JURY'S SIGNATURE		282. JURY'S TITLE		283. JURY'S ADDRESS		284. JURY'S PHONE		285. JURY'S FAX		286. JURY'S E-MAIL		287. JURY'S LICENSE		288. JURY'S BOARD		289. JURY'S SPECIALTY		290. JURY'S SIGNATURE	
291. JUDGE'S SIGNATURE		292. JUDGE'S TITLE		293. JUDGE'S ADDRESS		294. JUDGE'S PHONE		295. JUDGE'S FAX		296. JUDGE'S E-MAIL		297. JUDGE'S LICENSE		298. JUDGE'S BOARD		299. JUDGE'S SPECIALTY		300. JUDGE'S SIGNATURE	
301. DISTRICT ATTORNEY'S SIGNATURE		302. DISTRICT ATTORNEY'S TITLE		303. DISTRICT ATTORNEY'S ADDRESS		304. DISTRICT ATTORNEY'S PHONE		305. DISTRICT ATTORNEY'S FAX		306. DISTRICT ATTORNEY'S E-MAIL		307. DISTRICT ATTORNEY'S LICENSE		308. DISTRICT ATTORNEY'S BOARD		309. DISTRICT ATTORNEY'S SPECIALTY		310. DISTRICT ATTORNEY'S SIGNATURE	
311. COUNTY CLERK'S SIGNATURE		312. COUNTY CLERK'S TITLE		313. COUNTY CLERK'S ADDRESS		314. COUNTY CLERK'S PHONE		315. COUNTY CLERK'S FAX		316. COUNTY CLERK'S E-MAIL		317. COUNTY CLERK'S LICENSE		318. COUNTY CLERK'S BOARD		319. COUNTY CLERK'S SPECIALTY		320. COUNTY CLERK'S SIGNATURE	
321. VENDOR'S SIGNATURE		322. VENDOR'S TITLE		323. VENDOR'S ADDRESS		324. VENDOR'S PHONE		325. VENDOR'S FAX		326. VENDOR'S E-MAIL		327. VENDOR'S LICENSE		328. VENDOR'S BOARD		329. VENDOR'S SPECIALTY		330. VENDOR'S SIGNATURE	
331. WITNESS'S SIGNATURE		332. WITNESS'S TITLE		333. WITNESS'S ADDRESS		334. WITNESS'S PHONE		335. WITNESS'S FAX		336. WITNESS'S E-MAIL		337. WITNESS'S LICENSE		338. WITNESS'S BOARD		339. WITNESS'S SPECIALTY		340. WITNESS'S SIGNATURE	
341. JURY'S SIGNATURE		342. JURY'S TITLE		343. JURY'S ADDRESS		344. JURY'S PHONE		345. JURY'S FAX		346. JURY'S E-MAIL		347. JURY'S LICENSE		348. JURY'S BOARD		349. JURY'S SPECIALTY		350. JURY'S SIGNATURE	
351. JUDGE'S SIGNATURE		352. JUDGE'S TITLE		353. JUDGE'S ADDRESS		354. JUDGE'S PHONE		355. JUDGE'S FAX		356. JUDGE'S E-MAIL		357. JUDGE'S LICENSE		358. JUDGE'S BOARD		359. JUDGE'S SPECIALTY		360. JUDGE'S SIGNATURE	
361. DISTRICT ATTORNEY'S SIGNATURE		362. DISTRICT ATTORNEY'S TITLE		363. DISTRICT ATTORNEY'S ADDRESS		364. DISTRICT ATTORNEY'S PHONE		365. DISTRICT ATTORNEY'S FAX		366. DISTRICT ATTORNEY'S E-MAIL		367. DISTRICT ATTORNEY'S LICENSE		368. DISTRICT ATTORNEY'S BOARD		369. DISTRICT ATTORNEY'S SPECIALTY		370. DISTRICT ATTORNEY'S SIGNATURE	
371. COUNTY CLERK'S SIGNATURE		372. COUNTY CLERK'S TITLE		373. COUNTY CLERK'S ADDRESS		374. COUNTY CLERK'S PHONE		375. COUNTY CLERK'S FAX		376. COUNTY CLERK'S E-MAIL		377. COUNTY CLERK'S LICENSE		378. COUNTY CLERK'S BOARD		379. COUNTY CLERK'S SPECIALTY		380. COUNTY CLERK'S SIGNATURE	
381. VENDOR'S SIGNATURE		382. VENDOR'S TITLE		383. VENDOR'S ADDRESS		384. VENDOR'S PHONE		385. VENDOR'S FAX		386. VENDOR'S E-MAIL		387. VENDOR'S LICENSE		388. VENDOR'S BOARD		389. VENDOR'S SPECIALTY		390. VENDOR'S SIGNATURE	
391. WITNESS'S SIGNATURE		392. WITNESS'S TITLE		393. WITNESS'S ADDRESS		394. WITNESS'S PHONE		395. WITNESS'S FAX		396. WITNESS'S E-MAIL		397. WITNESS'S LICENSE		398. WITNESS'S BOARD		399. WITNESS'S SPECIALTY		400. WITNESS'S SIGNATURE	
401. JURY'S SIGNATURE		402. JURY'S TITLE		403. JURY'S ADDRESS		404. JURY'S PHONE		405. JURY'S FAX		406. JURY'S E-MAIL		407. JURY'S LICENSE		408. JURY'S BOARD		409. JURY'S SPECIALTY		410. JURY'S SIGNATURE	
411. JUDGE'S SIGNATURE		412. JUDGE'S TITLE		413. JUDGE'S ADDRESS		414. JUDGE'S PHONE		415. JUDGE'S FAX		416. JUDGE'S E-MAIL		417. JUDGE'S LICENSE		418. JUDGE'S BOARD		419. JUDGE'S SPECIALTY		420. JUDGE'S SIGNATURE	
421. DISTRICT ATTORNEY'S SIGNATURE		422. DISTRICT ATTORNEY'S TITLE		423. DISTRICT ATTORNEY'S ADDRESS		424. DISTRICT ATTORNEY'S PHONE		425. DISTRICT ATTORNEY'S FAX		426. DISTRICT ATTORNEY'S E-MAIL		427. DISTRICT ATTORNEY'S LICENSE		428. DISTRICT ATTORNEY'S BOARD		429. DISTRICT ATTORNEY'S SPECIALTY		430. DISTRICT ATTORNEY'S SIGNATURE	
431. COUNTY CLERK'S SIGNATURE		432. COUNTY CLERK'S TITLE		433. COUNTY CLERK'S ADDRESS		434. COUNTY CLERK'S PHONE		435. COUNTY CLERK'S FAX		436. COUNTY CLERK'S E-MAIL		437. COUNTY CLERK'S LICENSE		438. COUNTY CLERK'S BOARD		439. COUNTY CLERK'S SPECIALTY		440. COUNTY CLERK'S SIGNATURE	
441. VENDOR'S SIGNATURE		442. VENDOR'S TITLE		443. VENDOR'S ADDRESS		444. VENDOR'S PHONE		445. VENDOR'S FAX		446. VENDOR'S E-MAIL		447. VENDOR'S LICENSE		448. VENDOR'S BOARD		449. VENDOR'S SPECIALTY		450. VENDOR'S SIGNATURE	
451. WITNESS'S SIGNATURE		452. WITNESS'S TITLE		453. WITNESS'S ADDRESS		454. WITNESS'S PHONE		455. WITNESS'S FAX		456. W									

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8131 CERTIFICATE OF DEATH

Reg. Dist. No. 219

08090

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 Hr. 30 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Kathryn</b> Last <b>CONSTABLE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 July 1958</b>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>30</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jack Roland CONSTABLE</b>		14. MOTHER'S MAIDEN NAME <b>Betty L. PERRY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>	
17. INFORMANT <b>Father, Jack L. Constable (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IMMATURITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMATUNITY</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8 July</b> , 19 <b>58</b> , to <b>8 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 July</b> , 19 <b>58</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel Shuptar</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-10-58</b>	
PHYSICIAN'S NAME (Type) <b>Daniel Shuptar, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Murphy Funeral Home</b>		ADDRESS <b>Arlington, Va.</b>	
24a. REC'D BY REGISTRAR <b>DATE Jul 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

2051201XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove, carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8064

## CERTIFICATE OF DEATH

Reg. Dist. No. 88091

1. PLACE OF DEATH a. COUNTY <u>517 ALBANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>1 MONTH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAK HAVEN REST HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC. 47th St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>W</u> Last <u>COSTELLO</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>3rd</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>9</u> Days <u>5</u> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD WORTHINGTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY A PIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>DAUGHTER (MISS COSTELLO)</u>		Address <u>3126 16th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 19 58</u> , to <u>July 19 58</u> , that I last saw the deceased alive on <u>7/3/58</u> , 19____, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Lawrence A. Rapee</u> M.D. <u>150 Conn Ave NW 7/3/58</u> PHYSICIAN'S NAME (Type) <u>LAWRENCE RAPEE</u> <u>Washington 6, DC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Logan County, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Archer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

NAME OF DECEASED  
JAMES H. BROWN

AGE  
45

SEX  
Male

DATE OF DEATH  
Jan 15 1900

PLACE OF DEATH  
St. Louis, Mo.

CAUSE OF DEATH  
Heart Disease

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

DATE OF BIRTH  
Jan 15 1855

PLACE OF BIRTH  
St. Louis, Mo.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2322 Blue Ridge Ave</u>			1d. STREET ADDRESS <u>2322 Blue Ridge Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Catherine Ellen Culliton</u> First Middle Last			4. DATE OF DEATH <u>July 12 1958</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-0x</u>		9. AGE (In years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u>
13. FATHER'S NAME <u>John Mulhoolly</u>			14. MOTHER'S MAIDEN NAME <u>Mary A. Lynch</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Kenneth Patrick</u> Address <u>5817 Steeles Rd Wash DC</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-12-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS			24a. REC'D BY REGISTRAR <u>JUL 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE STATE  
DEPT. OF HEALTH

1. NAME OF DECEASED: JOHN J. JONES

2. SEX: MALE

3. AGE: 45

4. OCCUPATION: CLERK

5. PLACE OF BIRTH: NEW YORK

6. DATE OF BIRTH: 1910

7. PLACE OF DEATH: HOME

8. DATE OF DEATH: 1950

9. TIME OF DEATH: 10:00 AM

10. CAUSE OF DEATH: HEART DISEASE

11. MANNER OF DEATH: NATURAL

12. SIGNATURE OF EXAMINER: JOHN J. JONES

13. SIGNATURE OF WITNESS: JOHN J. JONES

14. SIGNATURE OF CORONER: JOHN J. JONES

15. SIGNATURE OF JURY: JOHN J. JONES

16. SIGNATURE OF JUDGE: JOHN J. JONES

17. SIGNATURE OF CLERK: JOHN J. JONES

18. SIGNATURE OF NURSE: JOHN J. JONES

19. SIGNATURE OF PHYSICIAN: JOHN J. JONES

20. SIGNATURE OF PATHOLOGIST: JOHN J. JONES

21. SIGNATURE OF ANATOMIST: JOHN J. JONES

22. SIGNATURE OF HISTOLOGIST: JOHN J. JONES

23. SIGNATURE OF MICROSCOPIC: JOHN J. JONES

24. SIGNATURE OF RADIOLOGIST: JOHN J. JONES

25. SIGNATURE OF CLINICAL: JOHN J. JONES

26. SIGNATURE OF LABORATORY: JOHN J. JONES

27. SIGNATURE OF PHARMACY: JOHN J. JONES

28. SIGNATURE OF HOSPITAL: JOHN J. JONES

29. SIGNATURE OF NURSING: JOHN J. JONES

30. SIGNATURE OF MEDICAL: JOHN J. JONES

31. SIGNATURE OF DENTAL: JOHN J. JONES

32. SIGNATURE OF OPTIC: JOHN J. JONES

33. SIGNATURE OF SURGICAL: JOHN J. JONES

34. SIGNATURE OF OBSTETRIC: JOHN J. JONES

35. SIGNATURE OF PEDIATRIC: JOHN J. JONES

36. SIGNATURE OF PSYCHIATRIC: JOHN J. JONES

37. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

38. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

39. SIGNATURE OF ANATOMICAL: JOHN J. JONES

40. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

41. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

42. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

43. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

44. SIGNATURE OF ANATOMICAL: JOHN J. JONES

45. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

46. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

47. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

48. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

49. SIGNATURE OF ANATOMICAL: JOHN J. JONES

50. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

51. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

52. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

53. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

54. SIGNATURE OF ANATOMICAL: JOHN J. JONES

55. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

56. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

57. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

58. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

59. SIGNATURE OF ANATOMICAL: JOHN J. JONES

60. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

61. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

62. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

63. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

64. SIGNATURE OF ANATOMICAL: JOHN J. JONES

65. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

66. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

67. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

68. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

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71. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

72. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

73. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

74. SIGNATURE OF ANATOMICAL: JOHN J. JONES

75. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

76. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

77. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

78. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

79. SIGNATURE OF ANATOMICAL: JOHN J. JONES

80. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

81. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

82. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

83. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

84. SIGNATURE OF ANATOMICAL: JOHN J. JONES

85. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

86. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

87. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

88. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

89. SIGNATURE OF ANATOMICAL: JOHN J. JONES

90. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

91. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

92. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

93. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

94. SIGNATURE OF ANATOMICAL: JOHN J. JONES

95. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

96. SIGNATURE OF MICROSCOPICAL: JOHN J. JONES

97. SIGNATURE OF RADIOLOGICAL: JOHN J. JONES

98. SIGNATURE OF PATHOLOGICAL: JOHN J. JONES

99. SIGNATURE OF ANATOMICAL: JOHN J. JONES

100. SIGNATURE OF HISTOLOGICAL: JOHN J. JONES

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1  
FOR STATE HEALTH DEPT.  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Md. R-115 near Md. R-124</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Ford</b> Last <b>Davidson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8th 1933</b>
9. AGE (In years last birthday) <b>25 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saltville Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Hugh Davidson</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Lawrence</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>226-38-0120</b>	
17. INFORMANT <b>Billie C. Davidson. Derwood.Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of cervical spine</b> <b>823x</b> DUE TO <b>auto accident</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Fractures of jaw, rt arm rt. hip and rt. knee</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which sideswiped pole</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:30 p.m. 7/28/58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) (County) (State) <b>Gaithersburg Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Saltville</b>		22d. LOCATION (City, town, or county) (State) <b>Saltville Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frye Funeral Home. Saltville. Va.,</b>		24a. REC'D BY REGISTRAR <b>JUL 30 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	



# 1 8065 Item 7 Film 231 7-11-58 et 8065 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 08094 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington, D.C.</i> b. COUNTY <i>47x-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakewood Park</i>		c. LENGTH OF STAY IN 1b <i>5-Weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		d. STREET ADDRESS <i>3041 Sedgwick St. NW</i>	
3. NAME OF DECEASED (Type or print) <i>Quice Elizabeth Davis</i>		4. DATE OF DEATH <i>July 1 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/10/72</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas W. Roberts</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Moore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>944.0</i> (b) <i>Posterior Coronary occlusion</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Glomerulonephritis &amp; Anemia &amp; Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>4 days</i> <i>20 years</i> <i>5 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Patient fell and broke right hip</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3:00</i> <i>a. m.</i> <i>May 25 1958</i> <i>p. m.</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <i>Home</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Washington, D.C.</i> (County) (State)	
21. I certify that I attended the deceased from <i>8/1/54</i> , 19 <i>54</i> , to <i>7/1/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/1/58</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Russell B. Arnold</i> M.D.		ADDRESS (Street, city or town, state) <i>8801 Colesville Rd, Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5 July 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Mr. Rainer, Md.</i>		ADDRESS <i>—</i>	
24a. REC'D BY REGISTRAR <i>JUL 7 1958</i>		24b. REGISTRAR'S SIGNATURE <i>W. T. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE

DECEASED'S NAME (Print or Write)

AGE

SEX

PLACE OF BIRTH (City, State, Country)

DATE OF BIRTH

TIME

PLACE

CAUSE

DIAGNOSIS

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08095

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> c. LENGTH OF STAY IN 1b <u>16-15-2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dickerson Quarry</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. g.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hgattsville</u> d. STREET ADDRESS <u>5600 16th Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ralph Edward Davis</u> First Middle Last <b>4. DATE OF DEATH</b> <u>July 4 1958</u> Month Day Year		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 20 1940</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>17</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tobacco house</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>D. C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. C.</u>		<b>13. FATHER'S NAME</b> <u>Cecil Davis</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Eleanor Thompson</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>212-38-3348</u> <b>17. INFORMANT</b> <u>Cecil Davis (father)</u> Address <u>Stm 2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Choking</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
<b>19a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>20a. TIME OF INJURY</b> Month, Day, Year <u>7-4 1958</u> Hour <u>4:55</u> a.m. p.m.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>drowned while swimming</u> <b>20c. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Quarry</u> <b>20e. (City or town)</b> <u>Dickerson Montg</u> (County) <u>md</u> (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>7-7-58</u> DATE SIGNED	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>JULY 10, 1958</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. REST</u>		<b>22d. LOCATION (City, town, or county)</b> <u>LAPLATA, MARYLAND</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Co. Inc. Washington, D.C.</u> <b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> <u>JUL 11 '58</u> <b>DATE</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. W. Chambers</u>		<b>24c. REGISTRAR'S SIGNATURE</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON 12



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8135

## CERTIFICATE OF DEATH

08096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>San Echo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Echo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11 Vassar Circle</i>		d. STREET ADDRESS <i>11 Vassar Circle</i>	
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>P.</i> Last <i>DePaolis</i>		4. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 8, 1901</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>PENNA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JOHN MINNS</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Alfred J. DePaolis</i>		Address <i>11 Vassar Circle</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ovarian Carcinoma</i> <i>175.0</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 15</i> , 19 <i>58</i> , to <i>July 27</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>July 27</i> , 19 <i>58</i> , and that death occurred at <i>11:45</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry N. Carlton</i>		DATE SIGNED <i>7/27/58</i>	
PHYSICIAN'S NAME (Type) <i>HARRY N. CARLTON</i>		ADDRESS (Street, city or town, state) <i>1816 R STREET, N.W. - WASHINGTON, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JULY 30, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL MEMORIAL PARK</i>		22d. LOCATION (City, town, or county) (State) <i>Virginia, Falls Church</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don. DePol</i>		ADDRESS <i>2224 - Wis. Ave NW</i>	
24a. REC'D BY REGISTRAR <i>Jul 31 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred J. DePaolis</i>	



8136

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Nathan</u> first Middle <u>Dimes</u> Last		4. DATE OF DEATH <u>July 8</u> Month <u>8</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1891</u> vs. <u>1897</u>
9. AGE (In years last birthday) <u>67</u> vs. <u>61</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Dimes</u>		14. MOTHER'S MAIDEN NAME <u>Emma Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary F. Dimes - Dimes Road Rockville, Md.</u> (Address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene Extremities Coma</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis Generalized</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1947</u> to <u>July 8, 1958</u> , that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>12:07 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D. <u>Norbeck</u>		DATE SIGNED <u>7-9-58</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		<u>Alvey Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>	22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Souden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alvey Spring</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8137 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Garfield Durall</u>		4. DATE OF DEATH Month Day Year <u>7 1 19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/32</u>
9. AGE (In years lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Luther A. Durall</u>		14. MOTHER'S MAIDEN NAME <u>Ida Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 20 9654</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Agotemia</u> 442X DUE TO <u>Cardiovascular - renal disease, with hyper-tension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>5 years</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cataracts</u> <u>Amputated left leg, for skin malignancy in burn scar</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19 58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , to <u>July 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>58</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Staff. Laithersburg</u> M.D. <u>26 N. Summit Ave.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Laithersburg, Md.</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 3</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville, Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 58</u>	24b. REGISTRAR'S SIGNATURE <u>Overman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MINIMUM  
FIVE  
CENTS  
PER  
COPY

SEE PAGE 100

City of Lexington, Mass. July 2, 1911

Lexington, Mass.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood (rural)</b>		c. LENGTH OF STAY IN 1b <b>9 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD # 1</b>			d. STREET ADDRESS <b>RFD # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James Edward Earp</b>			4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaping business</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Earp</b>			14. MOTHER'S MAIDEN NAME <b>Jennie Cowens</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clinton Earp (son)</b> Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>7/21/58</b>	
22a. BURIAL, CREMATION, REMOVAL (State city) <b>Burial</b>		22b. DATE THEREOF <b>7-24-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	
22d. LOCATION (City, town, or county) <b>Gaithersburg</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>		ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 24 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8139 CERTIFICATE OF DEATH

Reg. Dist. No. 08100

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>5½ yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11,918 Valleywood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>HURST</b> Last <b>ECKE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/92</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Erickson Rug. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>(Unknown) Hurst</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>170-09-8148A</b>	
17. INFORMANT <b>Mr. Raymond Reid</b>		Address <b>11,918 Valleywood Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b> DUE TO (c) <b>C. of Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 19, 1958</b> to <b>July 1958</b> , that I last saw the deceased alive on <b>July 15, 1958</b> , and that death occurred at <b>July 25, 1958</b> M. From the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Frank G. Leslie</b> M.D. <b>8901 Ba An Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>Frank G. Leslie</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 7/25/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>SCRANTON, PENNSYLVANIA</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner C. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>28 '58</b>		24b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8140

Item 6 Film 0233 8-27-58 et  
 CERTIFICATE OF DEATH

Reg. Dist. No.

08101

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown</i> c. LENGTH OF STAY IN 1b <i>3 months</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Marylander Rest Home</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i> d. STREET ADDRESS <i>717 Portland St. S. E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>CLARA LOUISE</i> First Middle Last		<b>4. DATE OF DEATH</b> Month <i>7</i> Day <i>27</i> Year <i>1958</i>		<b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <i>Sept. 3, 1881</i> <b>9. AGE</b> (In years last birthday) <i>76</i> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>None</i> <b>11. BIRTHPLACE</b> (State or foreign country) <i>Texas</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>		<b>13. FATHER'S NAME</b> <i>Frank C Povenmire</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Tenant</i>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i> <b>16. SOCIAL SECURITY NO.</b> <i>no</i> <b>17. INFORMANT</b> <i>Robert F Eckles</i> Address <i>Rockville Md 5608 Allentown Ave</i>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute left ventricular failure</i> DUE TO (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>few weeks</i> <i>5 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <i>March 1958 to July 27 1958</i> <b>that I last saw the deceased alive on</b> <i>July 26 1958</i> <b>and that death occurred at</b> <i>5:30 P.M.</i> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <i>W. A. Linthicum</i> M.D. <i>26 N. Summit Ave</i> <b>DATE SIGNED</b> <i>7/27/58</i> <b>PHYSICIAN'S NAME (Type)</b> <i>WM. A. LINTHICUM</i> <i>Southbury, Md.</i>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>BURIAL</i> <b>22b. DATE THEREOF</b> <i>JULY 31 1958</i> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Allentown Church Cem</i> <b>22d. LOCATION (City, town, or county)</b> <i>Lima Ohio</i> (State)		<b>24a. REC'D BY REGISTRAR</b> <i>JUL 31 58</i> <b>DATE</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>W. A. Linthicum</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8141 CERTIFICATE OF DEATH

Reg. Dist. No. 08102

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		d. STREET ADDRESS 3729 Morrison Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Virginia Fant		4. DATE OF DEATH Month Day Year July 11, 1958 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/16	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teletype operator Government		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Thomas Ewing Fant		14. MOTHER'S MAIDEN NAME LaBerta Cedelia Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-14-5626		17. INFORMANT LaBerta C. Wildman 3729 Morrison St. N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		Multiple Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 11 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16-1947 to 7-11-1958, that I last saw the deceased alive on 7-10-1958, and that death occurred at 9:40 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Thomas A. Wildman		M.D. 3729 Morrison St. N.W. Washington 15, D.C.		DATE SIGNED 7-11-58	
PHYSICIAN'S NAME (Type)					
22a. BURIAL CREMATION REMAINS (Specify) burial		22b. DATE THEREOF 7/15/58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery	
				22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE A. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

DECEASED  
NAME  
AGE  
SEX  
RACE  
BIRTH  
PLACE  
DATE  
OCCUPATION  
CAUSE  
MANNER  
PLACE  
DATE  
SIGNATURE  
OFFICIAL

Multiple Sclerosis

11 yrs

11-11-18

11-11-18

11-11-18

11-11-18

11-11-18

11-11-18

11-11-18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08103

8142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>L</u> Last <u>FARMER</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/29/1880</u>	
9. AGE (In year last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u>19</u> Min. <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Lewis H. Jones</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>HUSBAND - SAME as ABOVE</u>		17. INFORMANT Address <u>SAME as ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Pulmonary edema, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, generalized</u> DUE TO (c) <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October</u> , 19 <u>56</u> , to <u>25 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>24 July</u> , 19 <u>58</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Wyman</u> M.D.				DATE SIGNED <u>25 July 58</u>			
PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>				ADDRESS <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901-14th St. N.W.</u>				24. REC'D BY REGISTRAR <u>JUL 28 '58</u>		25. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8066

CERTIFICATE OF DEATH

Reg. Dist. No.

08104

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SANITARIUM-HOSPITAL</u>				d. STREET ADDRESS <u>31 Kennedy ST., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>FAVIN</u> Last <u>FAVIN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 19, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Owner of Industrial Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MUNISH FAVINSKY</u>				14. MOTHER'S MAIDEN NAME <u>ESTHER SHUPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>IRVING FAVIN 7408-16 AVE TR. PK. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ascending colon</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-renal failure</u> DUE TO (c) <u>Arteriosclerotic cerebro-vascular dis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>2 wks.</u> <u>2-3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 11, 1958</u> , to <u>July 4, 1958</u> , that I last saw the deceased alive on <u>July 3, 1958</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Smolheim</u>				ADDRESS (Street, city or town, state) <u>915-19th St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>DANIEL SMOLHEIMER</u>				DATE SIGNED <u>7/4/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom</u>		22d. LOCATION (City, town, or county) (State) <u>Hillside Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Davzaneky's sons</u>				ADDRESS <u>3501-14 St N.W. Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			

CERTIFICATE OF DEATH

8066

<p>1. NAME OF DECEASED                  [Illegible Name]</p>		<p>2. SEX                  [Illegible]</p>		<p>3. AGE                  [Illegible]</p>	
<p>4. DATE OF DEATH                  [Illegible]</p>		<p>5. TIME OF DEATH                  [Illegible]</p>		<p>6. PLACE OF DEATH                  [Illegible]</p>	
<p>7. CAUSE OF DEATH                  [Illegible]</p>		<p>8. MANNER OF DEATH                  [Illegible]</p>		<p>9. PLACE OF BIRTH                  [Illegible]</p>	
<p>10. OCCUPATION                  [Illegible]</p>		<p>11. MARITAL STATUS                  [Illegible]</p>		<p>12. EDUCATION                  [Illegible]</p>	
<p>13. PREVIOUS ILLNESS                  [Illegible]</p>		<p>14. PRESENT ILLNESS                  [Illegible]</p>		<p>15. MEDICAL HISTORY                  [Illegible]</p>	
<p>16. SIGNATURE OF PHYSICIAN                  [Illegible Signature]</p>		<p>17. SIGNATURE OF DECEASED                  [Illegible Signature]</p>		<p>18. SIGNATURE OF WITNESS                  [Illegible Signature]</p>	
<p>19. SIGNATURE OF REGISTRAR                  [Illegible Signature]</p>		<p>20. SIGNATURE OF CLERK                  [Illegible Signature]</p>		<p>21. SIGNATURE OF JURY                  [Illegible Signature]</p>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08105

8143

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 mos. 5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>FLATLEY</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1906</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James H. FLATLEY</b>				14. MOTHER'S MAIDEN NAME <b>Joan NASH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 7-07-27 to 6-2-58</b>		16. SOCIAL SECURITY NO. <b>396 38 0472</b>		17. INFORMANT Address <b>(Wife) Mrs. Dorothy M. Flatley (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of Right Lung with</b> <b>163X</b> DUE TO <b>Regional Lymph Node and Cerebral Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos. 7</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Jan.</b> , 19 <b>58</b> , to <b>9 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 July</b> , 19 <b>58</b> , and that death occurred at <b>4:35A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thirl E. Jarrett</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-9-58</b>			
PHYSICIAN'S NAME (Type) <b>Thirl E. Jarrett, Capt. MC. USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial c</b>		22b. DATE THEREOF <b>7-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, 1400 Chapin St., N.W. Wash. D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08106

8144

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> <del>7017 Beechwood Dr.</del>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENNINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENNINGTON GARDENS NURSING HOME</b>		d. STREET ADDRESS <b>7017 Beechwood Dr.</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES M. FORRESTER</b>		4. DATE OF DEATH <b>July 5, 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR <b>8</b> Months <b>6</b> Days <b>8</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Cont.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Forrester</b>		14. MOTHER'S MAIDEN NAME <b>Charolte B. Millar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Judge Bruce M. Forrester</b>		Address <b>7017 Beechwood Dr. Ch. 8h</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL DECOMPENSATION</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>5+ YEARS</b> <b>10+ YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>491X BRONCHOPNEUMONIA, RECURRENT</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 22, 1957</b> to <b>JULY 5, 1958</b> , that I last saw the deceased alive on <b>JULY 5, 1958</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1025 - CONN. AVE., WASH., D.C.</b> DATE SIGNED <b>JULY 5, '58</b>			
ACTUAL SIGNATURE <b>James W. Long</b>		M.D. <b>1025 - CONN. AVE., WASH., D.C.</b>	
PHYSICIAN'S NAME (Type) <b>JAMES W. LONG</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>7557 Wisc. Ave. Bethesda, Md.</b>	24a. REC'D BY REGISTRAR <b>JUL 9 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8067

## CERTIFICATE OF DEATH

Reg. Dist. No. 08107

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>7508 Carroll Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie Blanche Fugit</u>		4. DATE OF DEATH <u>July 11 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
13. FATHER'S NAME <u>Jesse E. Whitlock</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Morrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Record</u> Address	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric HEMORRHAGE</u> <u>MASSIVE from</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GASTRIC ULCER.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-9-58</u> , 19 <u>58</u> , to <u>7-11-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-11-58</u> , 19 <u>58</u> , and that death occurred at <u>440 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur E Coyne</u> M.D.		ADDRESS (Street, city or town, state) <u>7608 Carroll Ave Takoma Park.</u> DATE SIGNED <u>7-12-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 14, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wallers, 254 Carroll St NW HC</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8068

CERTIFICATE OF DEATH

Reg. Dist. No.

08108

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Rowe</u> Last <u>Geweher</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1876</u>
9. AGE (In years) <u>81</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penn. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pillow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. M. Gewehr</u>		Address <u>7300 Willow Ave Takoma Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Gen. Arteriosclerosis &amp; Hypertension</u> DUE TO (c) <u>Chr. Deg. Myocarditis &amp; Angina</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6/26/58</u> <u>10 yrs</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/22/1949</u> to <u>7/2/1958</u> , that I last saw the deceased alive on <u>7/1/58</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		DATE SIGNED <u>7/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Cty., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Buecker Sons</u>		ADDRESS <u>Washington DC</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	
DATE <u>JUL 7 1958</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8145

CERTIFICATE OF DEATH

08109

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>40 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>	d. STREET ADDRESS <u>406 Monroe St Apt #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F</u> Last <u>GOLDEN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting Co.</u>	
11. FATHER'S NAME <u>James Ward Golden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. MOTHER'S MAIDEN NAME <u>JANE Watson</u>		14. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-14-6789</u>	
17. INFORMANT <u>Mary Evelyn Golden - Wife</u>		18. ADDRESS <u>Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>45 hrs</u> <u>Indet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>7</u> Day <u>5</u> Year <u>1958</u> Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1957</u> , to <u>7/5/58</u> , that I last saw the deceased alive on <u>7/5/58</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u>		DATE SIGNED <u>7/5/58</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>		ADDRESS (Street, city or town, state) <u>Rockville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		24a. REG'D BY REGISTRAR <u>JUL 9 1958</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4.7 Film 0231 7-15-58 et

8069

## CERTIFICATE OF DEATH

08110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING MD</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. SANATARIAN AND Hosp.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>GOMBERG</b> Last			4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>'19 58</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1890</b>	9. AGE (In years, lost by day) <b>68</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>HARRY GOMBERG-</b>			14. MOTHER'S MAIDEN NAME <b>REBECCA CHABED</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <b>Hosp Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>9 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1949</b> , 19 <b>7/7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/25</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Irving W. Winik</b>			ADDRESS (Street, city or town, state) DATE SIGNED <b>3900 Neckerley St NW 7/7/58</b>		
PHYSICIAN'S NAME (Type) <b>Irving W. Winik, M.D.</b>			<b>Washington, D.C.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/9/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM GARDEN</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Wauzinsky &amp; Sons</b>			ADDRESS <b>3501-14th St. NW Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 11 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8070

## CERTIFICATE OF DEATH

08111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington, Jan &amp; Hospital</u>				d. STREET ADDRESS <u>1125 Spring Road, N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>(NMN)</u> Middle <u>Goodman</u> Last				4. DATE OF DEATH <u>July</u> Month <u>4</u> Day <u>1958</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-79</u> 9. AGE (In years, last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>	
13. FATHER'S NAME <u>Sigmond Rosenblatt</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA Goldsmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>PH chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastritis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2, 1958</u> , to <u>July 4, 1958</u> , that I last saw the deceased alive on <u>July 3, 1958</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. Danish</u> M.D.				ADDRESS (Street, city or town, state) <u>927 PERSHING DR. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>				DATE SIGNED <u>7-4-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew-Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons</u> ADDRESS <u>3501-14 St. N.W.</u>				24a. REC'D BY REGISTRAR <u>JUL 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

MEDICAL CERTIFICATION

75

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2

CERTIFICATE OF DEATH

8070

NAME OF DECEASED		DATE OF DEATH	
JAMES O. JAMES		JAN 10 1941	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTHPLACE		PLACE OF BIRTH	
MD		MD	
MARRIED		CAUSE OF DEATH	
Y		HEART DISEASE	
PREVIOUS ILLNESS		MANNER OF DEATH	
NONE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. O. JAMES		J. O. JAMES	
DATE		DATE	
JAN 10 1941		JAN 10 1941	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

ISSUED BY THE MARYLAND DEPARTMENT OF HEALTH

DATE OF ISSUE

JAN 10 1941

FILE NO. 107-11

## CERTIFICATE OF DEATH

Reg. Dist. No.

08112

8146

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. STREET ADDRESS <b>Rockville RFD # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Henry</b> Last <b>Gray</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1979</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Marketer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Russell W. Gray</b>			
				Address <b>Silver Spring, Md. 718 Chesapeake Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b> DUE TO (c) <b>coronary arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b> <b>72 hr</b> <b>Indef</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19 53</b> to <b>7/8/ 19 58</b> , that I last saw the deceased alive on <b>7/8/ 19 58</b> , and that death occurred at <b>11:58 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>7/9/58</b>							
ACTUAL SIGNATURE <b>Stephen H. Jones</b> M.D.			PHYSICIAN'S NAME (Type) <b>Rockville, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Potomac M.E. Church</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>				24. REC'D BY REGISTRAR <b>DATE JUL 11 58</b>		25. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8147 CERTIFICATE OF DEATH

Reg. Dist. No.

08113

1. PLACE OF DEATH a. COUNTY <u>Mona.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane, 9810 Georgia Ave. Silver Spring</u>		d. STREET ADDRESS <u>2707 Adams Mills Road N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>C.</u> Last <u>GRAY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk U.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
13. FATHER'S NAME <u>Samuel Gray</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Calwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-20-5165</u>	
17. INFORMANT <u>Chas. B. Gray-6508 Barnaby St. N.W.</u>		Address <u>Washington, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 9</u> , 19 <u>57</u> , to <u>JULY 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JULY 12</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowdon</u>		ADDRESS (Street, city or town, state) <u>5206 Newbury Dr.</u>	
PHYSICIAN'S NAME (Type) <u>Henry M. Lowdon</u>		DATE SIGNED <u>7/12/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>JUL 15 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  WILSON, JAMES H.</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  45</p>		<p>4. DATE OF BIRTH                  Jan 15, 1890</p>		<p>5. PLACE OF BIRTH                  Baltimore, Md.</p>	
<p>6. OCCUPATION                  Clerk</p>		<p>7. MARITAL STATUS                  Single</p>		<p>8. COLOR                  White</p>		<p>9. RELIGION                  Protestant</p>		<p>10. EDUCATION                  High School</p>	
<p>11. DECEASED'S ADDRESS                  1234 N. Broadway St., Baltimore, Md.</p>		<p>12. DECEASED'S PHONE                  1234</p>		<p>13. DECEASED'S SOCIAL SECURITY NUMBER                  123-45-6789</p>		<p>14. DECEASED'S MARRIAGE LICENSE                  None</p>		<p>15. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>16. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>17. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>18. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>19. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>20. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>21. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>22. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>23. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>24. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>25. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>26. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>27. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>28. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>29. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>30. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>31. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>32. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>33. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>34. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>35. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>36. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>37. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>38. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>39. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>40. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>41. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>42. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>43. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>44. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>45. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>46. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>47. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>48. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>49. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>50. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>51. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>52. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>53. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>54. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>55. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>56. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>57. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>58. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>59. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>60. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>61. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>62. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>63. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>64. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>65. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>66. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>67. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>68. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>69. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>70. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>71. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>72. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>73. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>74. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>75. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>76. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>77. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>78. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>79. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>80. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>81. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>82. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>83. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>84. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>85. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>86. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>87. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>88. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>89. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>90. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>91. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>92. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>93. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>94. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>95. DECEASED'S PREVIOUS RESIDENCE                  None</p>	
<p>96. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>97. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>98. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>99. DECEASED'S PREVIOUS RESIDENCE                  None</p>		<p>100. DECEASED'S PREVIOUS RESIDENCE                  None</p>	

TO BE FILLED BY THE REGISTRAR  
 1. DATE OF DEATH  
 2. PLACE OF DEATH  
 3. CAUSE OF DEATH  
 4. MANNER OF DEATH  
 5. MEDICAL ATTENDANT  
 6. CORONER  
 7. BURIAL PLACE  
 8. TIME OF BURIAL  
 9. NAME OF BURIAL PLACE  
 10. NAME OF BURIAL PLACE

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08114

## 8148 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Montgomery</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Rural Gaithersburg</b> TOWN <b>Life</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Montgomery</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. # 1</b> TOWN <b>X</b> STREET ADDRESS (If rural give location) <b>Gaithersburg,</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Gaithersburg, Rt. 1</b>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Gaithersburg,</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Charles Griffith</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>July 28 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 21 1877</b>	9. AGE last birthday <b>81</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Hester Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 12 8183</b>		17. INFORMANT & ADDRESS <b>Margaret B. Griffith</b>		Same As # <b>2</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <b>Arteriosclerotic Heart</b>						4 years	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Diabetes</b>						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Arteriosclerosis - Joint</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 19 28 to July 21, 19 58, that I last saw the deceased alive on July 28, 19 58, and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE <b>Rach Schumacher</b>		M.D. <b>Gaithersburg, Md.</b>		DATE SIGNED <b>July 29-58</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>July 31</b>		NAME OF CEMETERY OR CREMATORY <b>Laytonville, Meth.</b>		LOCATION (City, town, or county) (State) <b>Laytonville, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>AUG 1 '58</b>		REGISTRAR'S SIGNATURE <b>W. H. Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b> ADDRESS <b>Laytonville, Md.</b>			

# CERTIFICATE OF DEATH

REG. NO. 12

LOCAL HEALTH OFFICER'S SIGNATURE

NAME **WILLIAM** **WILLIAMSON**

RESIDENCE

AGE **1.5.0**

SEX **MALE**

DATE OF DEATH **1917**

PLACE OF DEATH

DATE OF BIRTH **1915**

CAUSE OF DEATH

CHARACTER OF DEATH

DATE OF DEATH **1917**

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

U.S.A.

MALE

CERTIFICATE

CERTIFICATE

REGISTERED

REGISTERED

DATE

REGISTERED

REGISTERED

DATE

LOCAL HEALTH OFFICER'S SIGNATURE

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8071  
CERTIFICATE OF DEATH

08115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakema Park Md.</i>		c. LENGTH OF STAY IN 1b <i>10 min.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington San + Hospital</i>		e. STREET ADDRESS <i>E. 98 Ridgewood Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i> First <i>(NMN)</i> Middle <i>Grunfelder</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>1</i> Year <i>1958</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-16-75</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Asst-</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Berger</i>		14. MOTHER'S MAIDEN NAME <i>XXX unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Pls admission sheet</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hr.</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-1</i> , 19 <i>58</i> , to <i>7-1</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7-1</i> , 19 <i>58</i> , and that death occurred at <i>3:55 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A.W. Davis</i> M.D.		ADDRESS (Street, city or town, state) <i>927 Cushing St</i> DATE SIGNED <i>7-1-58</i>	
PHYSICIAN'S NAME (Type) <i>A.W. DAVIS</i>		<i>Silver Spring, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. &amp; BURIAL</i>		22b. DATE THEREOF <i>7/1/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MARYREST CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>DARLINGTON, NEW JERSEY</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wanner E. Humphrey</i> ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>JUL 2 '58</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>W. E. Humphrey</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8099 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08116

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12007 Galena Rd</u>				d. STREET ADDRESS <u>12007 Galena Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Ethelyn Bragdon Hamblen</u> First Middle b Last				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/22/94</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest J. Bragdon</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>A. L. Hamblen (husband)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>year</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-30-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



**1**  
FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkburg</u>	
c. LENGTH OF STAY IN 1b <u>11 yrs</u>		d. STREET ADDRESS <u>15 Hammond Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 Hammond Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otho Warner Hammond</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1873</u>
9. AGE (In years, month, day) <u>84 yrs</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron. Dep</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Mother: Alwilda Austin William Brown Warner</u>		14. MOTHER'S MAIDEN NAME <u>Alwilda Austin 203 MacArthur Rd Ruth H. Reschberg - Alexander Va</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frank J. Broschant</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart disease</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-22-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co, Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Jul 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
								</																					

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08118

8072

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUCIEN D HANSBROUGH</b>		4. DATE OF DEATH <b>July 4 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/1901</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft Inspector</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edwin Hansbrough</b>		14. MOTHER'S MAIDEN NAME <b>---Hansbrough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>554-01-5613</b>	
17. INFORMANT <b>Helen V. Hansbrough-8674 Piney Branch Rd.</b>		Address <b>Silver Spg. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/3</b> , 19 <b>58</b> , to <b>7/4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/4</b> , 19 <b>58</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>BENNETT ROBIN, M.D. 8723 PINEY BRANCH ROAD SILVER SPRING, MARYLAND</b> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The A. Hines Co</b>		24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

<p>1. NAME OF DECEASED                  JAMES L. BROWN</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  65</p>		<p>4. DATE OF BIRTH                  1910</p>	
<p>5. PLACE OF BIRTH                  Silver Spring</p>		<p>6. OCCUPATION                  Farmer</p>	
<p>7. MARITAL STATUS                  Married</p>		<p>8. DATE OF MARRIAGE                  1935</p>	
<p>9. NAME OF SPOUSE                  Mary L. Brown</p>		<p>10. DATE OF DEATH                  1975</p>	
<p>11. PLACE OF DEATH                  Home</p>		<p>12. CAUSE OF DEATH                  Heart Disease</p>	
<p>13. MEDICAL HISTORY                  Hypertension</p>		<p>14. SIGNATURE OF PHYSICIAN                  Dr. J. Smith</p>	
<p>15. SIGNATURE OF REGISTRAR                  J. Doe</p>		<p>16. OFFICIAL SEAL                  (Seal of the Registrar)</p>	

8150

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
c. LENGTH OF STAY IN 1b <u>373 days</u>				d. STREET ADDRESS <u>(no street address)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Harker</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 15, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>George W. Harker</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Childs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-14-9836</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and anaemia</u> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Severe pulmonary insufficiency</u> DUE TO (c) <u>Emphysema (bullous) and pulmonary fibrosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>1 year</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure; cor pulmonale</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 28, 1957</u> , to <u>July 6, 1958</u> , that I last saw the deceased alive on <u>July 6, 1958</u> , and that death occurred at <u>3:12 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alan F. Hofmann</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>ALAN F. HOFMANN</u>				DATE SIGNED <u>7/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glenndale Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>W. H. Beach</u> DATE <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Social Security Number	
13. Signature of Physician		14. Signature of Registrar		15. Signature of Informant		16. Date of Entry	
17. Signature of Medical Examiner		18. Signature of Coroner		19. Signature of Jury		20. Signature of Judge	
21. Signature of County Clerk		22. Signature of Mayor		23. Signature of City Clerk		24. Signature of School Board	
25. Signature of Board of Health		26. Signature of Board of Education		27. Signature of Board of Police		28. Signature of Board of Fire	
29. Signature of Board of Public Works		30. Signature of Board of Public Safety		31. Signature of Board of Public Health		32. Signature of Board of Public Welfare	
33. Signature of Board of Public Assistance		34. Signature of Board of Public Relief		35. Signature of Board of Public Charity		36. Signature of Board of Public Education	
37. Signature of Board of Public Instruction		38. Signature of Board of Public Training		39. Signature of Board of Public Employment		40. Signature of Board of Public Labor	
41. Signature of Board of Public Industry		42. Signature of Board of Public Commerce		43. Signature of Board of Public Finance		44. Signature of Board of Public Revenue	
45. Signature of Board of Public Taxation		46. Signature of Board of Public Assessment		47. Signature of Board of Public Valuation		48. Signature of Board of Public Appraisal	
49. Signature of Board of Public Auction		50. Signature of Board of Public Sale		51. Signature of Board of Public Leasing		52. Signature of Board of Public Lending	
53. Signature of Board of Public Borrowing		54. Signature of Board of Public Investing		55. Signature of Board of Public Holding		56. Signature of Board of Public Managing	
57. Signature of Board of Public Administering		58. Signature of Board of Public Disposing		59. Signature of Board of Public Distributing		60. Signature of Board of Public Delivering	
61. Signature of Board of Public Carrying		62. Signature of Board of Public Transporting		63. Signature of Board of Public Conveying		64. Signature of Board of Public Moving	
65. Signature of Board of Public Shifting		66. Signature of Board of Public Changing		67. Signature of Board of Public Turning		68. Signature of Board of Public Converting	
69. Signature of Board of Public Transforming		70. Signature of Board of Public Altering		71. Signature of Board of Public Repairing		72. Signature of Board of Public Restoring	
73. Signature of Board of Public Maintaining		74. Signature of Board of Public Preserving		75. Signature of Board of Public Protecting		76. Signature of Board of Public Defending	
77. Signature of Board of Public Attacking		78. Signature of Board of Public Fighting		79. Signature of Board of Public Winning		80. Signature of Board of Public Losing	
81. Signature of Board of Public Succeeding		82. Signature of Board of Public Failing		83. Signature of Board of Public Achieving		84. Signature of Board of Public Missing	
85. Signature of Board of Public Finding		86. Signature of Board of Public Missing		87. Signature of Board of Public Seeking		88. Signature of Board of Public Looking	
89. Signature of Board of Public Watching		90. Signature of Board of Public Waiting		91. Signature of Board of Public Hoping		92. Signature of Board of Public Expecting	
93. Signature of Board of Public Thinking		94. Signature of Board of Public Feeling		95. Signature of Board of Public Knowing		96. Signature of Board of Public Understanding	
97. Signature of Board of Public Remembering		98. Signature of Board of Public Forgetting		99. Signature of Board of Public Ignoring		100. Signature of Board of Public Noticing	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08120

Reg. Dist. No. 215

8151

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River (Valley Lee)</b> 18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cynthia</b> Middle <b>Ann</b> Last <b>HARLOW</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 May 1955</b>
9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>24</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Robert John HARLOW</b>	
14. MOTHER'S MAIDEN NAME <b>Claudia KING</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure &amp; Collapse</b> DUE TO (b) <b>Anoxia</b> DUE TO (c) <b>Staphylococcal Pneumonia, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Empyema and pulmonary abscesses</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 da</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>23 July</b> , 19 <b>58</b> , to <b>24 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>24 July</b> , 19 <b>58</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adam T Thorp Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-25-58</b>	
PHYSICIAN'S NAME (Type) <b>ADAM T. THORP, JR. LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Barrancas Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pensacola, Florida</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>JUL 29 58</b>	
ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08121

8073

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Infant Boy</u>		4. DATE OF DEATH <u>7-17-1958</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Warren Hartley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Joan Baggett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		17. INFORMANT <u>Mother's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/16/58</u> to <u>7/17/58</u> , that I last saw the deceased alive on <u>7/17/58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond F. Chinn</u>		ADDRESS (Street, city or town, state) <u>925 Pershing Drive</u> DATE SIGNED <u>7/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Raymond F. Chinn, M. D. 925 Pershing Drive, Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, Washington San. &amp; Hospital</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

2075264XVV

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08122

Reg. Dist. No.

8152

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>35 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Elizabeth</u> Last <u>Hauke</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Teacher &amp;</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vice Principal</u>	
11. BIRTHPLACE (State or foreign country) <u>TACOMA - WASH</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES F HAUKE</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE KELSEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Thrombosis</u> DUE TO (c) <u>Arteriosclerosis, Coronary Arteries</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>8 hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Acromiocyctosis, etiology indeterminate</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>July 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Corinne Cooper</u> M.D.		ADDRESS (Street, city or town, state) <u>104 S Washington ST Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>CORINNE COOPER</u>		DATE SIGNED <u>7-17-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8153 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>3524 754 S. Greenbriar St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Austin</b> Last <b>HEATHERLY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 July 1948</b>
9. AGE (In years last birthday) <b>10</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Floyd A. HEATHERLY</b>	
14. MOTHER'S MAIDEN NAME <b>Necie Marie AUSTIN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Father, Floyd A. HEATHERLY (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.3 Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Staphylococcal Pneumonia</b> DUE TO (c) <b>Acute Lymphoblastic Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>2 weeks</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>14 July</b> , 19 <b>58</b> , to <b>31 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>31 July</b> , 19 <b>58</b> , and that death occurred at <b>8:10A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adam G. Thorp, Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-31-58</b>	
PHYSICIAN'S NAME (Type) <b>Adam G. Thorp, Jr. LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.J. Murphy</b>		24a. REC'D BY REGISTRAR <b>AUG 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8154 CERTIFICATE OF DEATH

Reg. Dist. No.

08124

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>		d. STREET ADDRESS <b>2000 Osborn Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2000 Osborn Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rudolph</b> Middle <b>(NMI)</b> Last <b>Hellbach</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/26/81</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Instrument maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Hellbach</b>		14. MOTHER'S MAIDEN NAME <b>Emelie Schwanebeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Pauline E. Hellbach, 2000 Osborn Drive</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>10 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>58</b> , to <b>July 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 25</b> , 19 <b>58</b> , and that death occurred at <b>10:35</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10511 Summit Avenue</b> DATE SIGNED ACTUAL SIGNATURE <b>Horace W. Bernton</b> M.D. PHYSICIAN'S NAME (Type) <b>Horace Wright Bernton, M.D.</b> <b>Kensington, Montgomery County, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	



## 8155 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>19 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1306 Dale Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>AYEL</u> Last <u>HELSTING</u>		4. DATE OF DEATH Month <u>July</u> 3 Day <u>19</u> Year <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor (retired) Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>	
13. FATHER'S NAME <u>Abraham Helsing</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Carolina Janson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-24-1143</u>	
17. INFORMANT <u>Einar Helsing (son)</u>		Address <u>6840 Glenbrook Road Bethesda 14, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis, severe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral apoplexy; left hemiplegia - 3 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u> <u>4 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>54</u> to <u>July 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>58</u> , and that death occurred at <u>9:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Dewey</u> M.D.		ADDRESS (Street, city or town, state) <u>1629 Columbia Road, N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>George Dewey, M.D.</u>		DATE SIGNED <u>7/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a final burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

8156

## CERTIFICATE OF DEATH

08126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4612 Chevy Chase Blvd.</b>		d. STREET ADDRESS <b>1 4612 Chevy Chase Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>B</b> Last <b>HENDERSON</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>? Morris</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. John H. Blythe---same as 2-Cousin</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive heart disease</b> <b>443X</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-6-57</b> to <b>7-17-58</b> , that I last saw the deceased alive on <b>7-7-58</b> , and that death occurred at <b>3:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. P. Ryland</b>		ADDRESS (Street, city or town, state) <b>C. P. RYLAND, M.D. 4400 - 49th St., N. W. Washington 16, D. C.</b>	
PHYSICIAN'S NAME (Type) <b>C. P. Ryland</b>		DATE SIGNED <b>7-8-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUL 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allen</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a fire burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8157 CERTIFICATE OF DEATH

08127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmont</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmont</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4000 Maryland Ave.</b>				d. STREET ADDRESS <b>4000 Maryland Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ADDISON</b> Last <b>HIGGINS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1871</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
13. FATHER'S NAME <b>John Wessley Higgins</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane Sims</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Miss Helen Higgins</b> Address <b>4000 Maryland Av.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March</b> , 19 <b>58</b> , to <b>July 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 14</b> , 19 <b>58</b> , and that death occurred at <b>7-15-58</b> from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>Andrew E. Rudnai</b> M.D.				ADDRESS (Street, city or town, state) <b>5120 MacArthur Blvd. Washington DC.</b> DATE SIGNED <b>7/15/58</b>			
PHYSICIAN'S NAME (Type) <b>Andrew E. Rudnai</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons</b> ADDRESS <b>1750 Penna Av.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 18 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. Smith</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 232 8-15-58

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08128

Reg. Dist. No.

8100

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1216 Claggett Dr</u>		d. STREET ADDRESS <u>1216 Claggett Dr</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Debra Hilderbrand</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-58</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Hilderbrand, Jr</u>		14. MOTHER'S MAIDEN NAME <u>Drews Lumm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Father</u>		Address: <u>Same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> <u>525x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brozant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brozant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

2075244XV6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8158

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>15 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Garnier</b> Last <b>HILL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-95</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Eugene GARNIER</b>		14. MOTHER'S MAIDEN NAME <b>Augusta SPRINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT (Daughter) <b>Mrs. R.E. HOMMEL, 7905 Radnor Rd., Bethesda, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Ovary</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>12 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6 July</b> , 19 <b>58</b> , to <b>6 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 July</b> , 19 <b>58</b> , and that death occurred at <b>8:31P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. S. DUNN JR.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, Bethesda, Md. 7-6-58</b>	
PHYSICIAN'S NAME (Type) <b>T. S. DUNN JR., LT, MC, USN</b>		<b>U. S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. PUMPHREY</b>		ADDRESS <b>7557 Wisconsin Ave, Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		35		Jan 15, 1918		New York City	
Cause of death		Disease		Organ		Duration		Manner	
Pneumonia		Pneumonia		Lungs		10 days		Natural	
Place of birth		Date of birth		Sex		Color		Religion	
New York City		Jan 1, 1883		Male		White		Roman Catholic	
Occupation		Education		Married		Previous illness		Signature of physician	
Clerk		High School		Yes		None		John Doe, M.D.	
Signature of informant		Relationship		Address		City		State	
John Doe		Son		123 Main St		New York		NY	
Signature of registrar		Name		Address		City		State	
John Doe		John Doe		123 Main St		New York		NY	

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MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

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THE LATEST TRENDS IN DESIGN

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10-10-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08131

8160

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>9705 SUMMIT AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (REV.) (Type or print) <b>STEPHEN</b> First <b>J.</b> Middle <b>HOGAN</b> Last			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-05</b>		9. AGE (In years last birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CATHOLIC PRIEST</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN HOGAN</b>			14. MOTHER'S MAIDEN NAME <b>MARY ANNE QUINN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>REV. JOHN B. BRADY</b> Address <b>kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Atherosclerosis, Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Recent Myocardial Infarction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH <b>Stat</b> <b>5 wks.</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>April</b> , 19 <b>1957</b> to <b>Jul 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jul 15</b> , 19 <b>58</b> , and that death occurred at <b>@1:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 Concord St.</b> DATE SIGNED <b>Jul 19-58</b> ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b> <b>Kensington, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MOUNT OLIVET CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>FRANCIS J. COLLINS</b>		ADDRESS <b>WASH. D.C.</b> <b>3821 14th. St. N.W.</b>		24a. REC'D BY REGISTRAR <b>JUL 22 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Carver</b>

CERTIFICATE OF DEATH

1940

WILLIAM BROWN

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

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CERTIFICATE OF DEATH

08132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma PARK 17</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7113 SYCAMORE AVE</b>		d. STREET ADDRESS <b>7113 SYCAMORE AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arvine J Hoover</b>		4. DATE OF DEATH <b>July 15 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 9. 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Int. Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Hoover</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Finneran</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Minnie C Hoover (wife)</b>		Address <b>7113 Sycamore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of</b> <b>181.0</b> DUE TO <b>abdominal viscera</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary Carcinoma of Urinary</b> DUE TO <b>Bladder</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined 2 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intestinal obstruction, Obstructive Jaundice</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 2</b> , 19 <b>56</b> , to <b>July 15, 1958</b> and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7835 Eastern Ave</b> DATE SIGNED <b>July 15 1958</b>			
ACTUAL SIGNATURE <b>George L Ball</b> M.D.		PHYSICIAN'S NAME (Type) <b>George L Ball</b> <b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>17 July 1958</b>		22b. DATE THEREOF <b>Cedar Hill Cem. Suitland, Md.</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 4 + Main Ave NE.</b>		ADDRESS <b>4 + Main Ave NE.</b>	
24a. REC'D BY REGISTRAR <b>JUL 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Church</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BOYS

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montg.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>W.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i>		d. STREET ADDRESS <i>132 Hemlock Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Wash. San. Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Gertrude Hornaday</i>		4. DATE OF DEATH Month <i>7</i> Day <i>25</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/31/69</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Ind. U.S.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Frank W. Willis</i>	
14. MOTHER'S MAIDEN NAME <i>Josephine Wickens</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Harp Reed</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis &amp; Decomp.</i> <i>433.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arr. Fibrillation</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>7/6/58</i> , 1958, to <i>7/25/58</i> , 1958, that I last saw the deceased alive on <i>7/24/58</i> , 1958, and that death occurred at <i>9:00</i> A. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		ADDRESS (Street, city or town, state) <i>2030 Carroll Ave</i>	
PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		DATE SIGNED <i>7/25/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/27/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co.</i> ADDRESS <i>2901 14th St., N.W. Washington 9, D.C.</i>		24a. REC'D BY REGISTRAR <i>JUL 28 1958</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>W. T. Reed</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8161

CERTIFICATE OF DEATH

08134

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	c. LENGTH OF STAY IN 1b <i>3 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>102 Oxford St.</i>		d. STREET ADDRESS <i>102 Oxford Street</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>JOSEPHINE</i> Middle <i>E.</i> Last <i>Hughes</i>		4. DATE OF DEATH Month <i>July</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25, 1871</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Sullivan</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Wm J. Hughes</i>		Address <i>Cherry Chase 102 Oxford St. - Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Liver</i> DUE TO (b) <i>156.1</i> DUE TO (c) <i>156.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis General With gangrene of foot</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar. 15, 1958</i> to <i>July 24, 1958</i> , that I last saw the deceased alive on <i>July 20, 1958</i> , and that death occurred at <i>7 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank S. Bacon</i> M.D.		ADDRESS (Street, city or town, state) <i>1150 Conn Ave, N.W. Wash D.C.</i>	
DATE SIGNED <i>July 26, 1958</i>		DATE SIGNED <i>July 26, 1958</i>	
PHYSICIAN'S NAME (Type) <i>FRANK S. BACON, M.D.</i>		PHYSICIAN'S NAME (Type) <i>1150 - CONN. AVE N.W. WASHINGTON D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>JULY 26, 58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don. DeVol</i>		ADDRESS <i>2224 - Wis Ave. DC</i>	
24a. REC'D BY REGISTRAR <i>Jul 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>DeVos</i>	

CERTIFICATE OF DEATH

1911

Page 7 of 10

1. NAME OF DECEASED MAYNARD		2. SEX MALE		3. AGE 35		4. DATE OF BIRTH JAN 15 1876		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION CLOCK REPAIRER		7. CAUSE OF DEATH TUBERCULOSIS OF LUNGS		8. PERIOD OF ILLNESS 3 MONTHS		9. PLACE OF DEATH HOME		10. TIME OF DEATH 10:30 AM	
11. SIGNATURE OF PHYSICIAN J. H. [illegible]		12. SIGNATURE OF CLERK [illegible]		13. SIGNATURE OF WITNESS [illegible]		14. SIGNATURE OF DECEASED [illegible]		15. SIGNATURE OF NEAREST RELATIVE [illegible]	
16. PLACE OF INTERMENT CATHOLIC CHURCH		17. NAME OF CEMETERY [illegible]		18. NAME OF MINISTER [illegible]		19. NAME OF CHURCH [illegible]		20. NAME OF FUNERAL HOME [illegible]	
21. NAME OF CORONER [illegible]		22. NAME OF JURY [illegible]		23. NAME OF JURY [illegible]		24. NAME OF JURY [illegible]		25. NAME OF JURY [illegible]	
26. NAME OF JURY [illegible]		27. NAME OF JURY [illegible]		28. NAME OF JURY [illegible]		29. NAME OF JURY [illegible]		30. NAME OF JURY [illegible]	
31. NAME OF JURY [illegible]		32. NAME OF JURY [illegible]		33. NAME OF JURY [illegible]		34. NAME OF JURY [illegible]		35. NAME OF JURY [illegible]	
36. NAME OF JURY [illegible]		37. NAME OF JURY [illegible]		38. NAME OF JURY [illegible]		39. NAME OF JURY [illegible]		40. NAME OF JURY [illegible]	
41. NAME OF JURY [illegible]		42. NAME OF JURY [illegible]		43. NAME OF JURY [illegible]		44. NAME OF JURY [illegible]		45. NAME OF JURY [illegible]	
46. NAME OF JURY [illegible]		47. NAME OF JURY [illegible]		48. NAME OF JURY [illegible]		49. NAME OF JURY [illegible]		50. NAME OF JURY [illegible]	
51. NAME OF JURY [illegible]		52. NAME OF JURY [illegible]		53. NAME OF JURY [illegible]		54. NAME OF JURY [illegible]		55. NAME OF JURY [illegible]	
56. NAME OF JURY [illegible]		57. NAME OF JURY [illegible]		58. NAME OF JURY [illegible]		59. NAME OF JURY [illegible]		60. NAME OF JURY [illegible]	
61. NAME OF JURY [illegible]		62. NAME OF JURY [illegible]		63. NAME OF JURY [illegible]		64. NAME OF JURY [illegible]		65. NAME OF JURY [illegible]	
66. NAME OF JURY [illegible]		67. NAME OF JURY [illegible]		68. NAME OF JURY [illegible]		69. NAME OF JURY [illegible]		70. NAME OF JURY [illegible]	
71. NAME OF JURY [illegible]		72. NAME OF JURY [illegible]		73. NAME OF JURY [illegible]		74. NAME OF JURY [illegible]		75. NAME OF JURY [illegible]	
76. NAME OF JURY [illegible]		77. NAME OF JURY [illegible]		78. NAME OF JURY [illegible]		79. NAME OF JURY [illegible]		80. NAME OF JURY [illegible]	
81. NAME OF JURY [illegible]		82. NAME OF JURY [illegible]		83. NAME OF JURY [illegible]		84. NAME OF JURY [illegible]		85. NAME OF JURY [illegible]	
86. NAME OF JURY [illegible]		87. NAME OF JURY [illegible]		88. NAME OF JURY [illegible]		89. NAME OF JURY [illegible]		90. NAME OF JURY [illegible]	
91. NAME OF JURY [illegible]		92. NAME OF JURY [illegible]		93. NAME OF JURY [illegible]		94. NAME OF JURY [illegible]		95. NAME OF JURY [illegible]	
96. NAME OF JURY [illegible]		97. NAME OF JURY [illegible]		98. NAME OF JURY [illegible]		99. NAME OF JURY [illegible]		100. NAME OF JURY [illegible]	

THESE RECORDS ARE TO BE KEPT IN THE OFFICE OF THE CLERK OF THE BOARD OF HEALTH FOR A PERIOD OF FIFTY YEARS.

CLERK OF THE BOARD OF HEALTH

1911

8162

CERTIFICATE OF DEATH

Reg. Dist. No. 08135

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>District of Columbia</b> <b>COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5318 Colorado Avenue, N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Reu</b> Middle <b>Ennis</b> Last <b>Hughes</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> , Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 29, 1890</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Erastus Hughes</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Blew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-05-9792</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492X</b> <b>left lower lobe pneumonia, bacterial</b> DUE TO (b) <b>a gamma globulinemia</b> DUE TO (c) <b>12 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 19</b> , 19 <b>58</b> , to <b>July 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 10</b> , 19 <b>58</b> , and that death occurred at <b>9:37 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>7-10-58</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>John P. Utz, M. D.</b>				PHYSICIAN'S NAME (Type) <b>John P. Utz, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company</b>				ADDRESS <b>2901 14th St. N. W.</b>		24a. REC'D BY REGISTRAR <b>JUL 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arch...</b>							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Brown		Male		45		Jan 15, 1900		New York, N.Y.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		Jan 10, 1945		New York, N.Y.	
Physician		Hospital		Nurse		Burial Place		Burial Date	
Dr. J. H. Smith		St. Mary's Hospital		Mrs. J. H. Smith		St. Mary's Cemetery		Jan 12, 1945	
Signature of Physician		Signature of Nurse		Signature of Burial Place		Signature of Burial Date		Signature of Secretary	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08136

## 8076 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tatoma Park</u>		c. LENGTH OF STAY IN 1b <u>today plus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>				d. STREET ADDRESS <u>10012 Lorain Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Yetta</u> Middle <u>(WMM)</u> Last <u>Hurvitz</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Simon Gottlieb</u>				14. MOTHER'S MAIDEN NAME <u>Zisha</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>medical Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia of the right lung</u> 688.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Pyelonephritis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>One Week</u> <u>One Week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>July 25, 1958</u> to <u>July 28, 1958</u> , that I last saw the deceased alive on <u>July 25, 1958</u> , and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. Danish</u>		M.D. <u>927 Rushing Dr.</u>			ADDRESS (Street, city or town, state) <u>Silver Spring Md</u>		
PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>		DATE SIGNED <u>7-28-58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eisenetgrad Cemetery Washington - D.C.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington - D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>				ADDRESS <u>3501-14 St NW</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

CERTIFICATE OF DEATH

MD-2

1-10-01-11

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RETURN

DATE OF REENTRY

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

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8163

CERTIFICATE OF DEATH

08137

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>1415 Wheaton Lane</u>				1d. STREET ADDRESS <u>1415 Wheaton Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Brainard H.</u> Middle <u>Hyson</u> Last <u>Hyson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry Hyson</u>				14. MOTHER'S MAIDEN NAME <u>Emma Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Bessie E. Hyson</u>				Address <u>1415 Wheaton Lane, Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Cardiorenal Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 4, 1950</u> to <u>July 7, 1958</u> , that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>5:58 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Norbeck Silver Spring</u> DATE SIGNED <u>7.9.58</u>							
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>		<p>DATE OF DEATH <i>Jan 15 1910</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>RESIDENCE <i>123 Main St. Boston</i></p>		<p>DATE OF BIRTH <i>Jan 15 1865</i></p>		<p>PLACE OF BIRTH <i>Massachusetts</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>DIAGNOSIS <i>Myocardial Infarction</i></p>		<p>DATE OF INTERMENT <i>Jan 17 1910</i></p>	
<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>		<p>DATE OF DEATH <i>Jan 15 1910</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>RESIDENCE <i>123 Main St. Boston</i></p>		<p>DATE OF BIRTH <i>Jan 15 1865</i></p>		<p>PLACE OF BIRTH <i>Massachusetts</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>DIAGNOSIS <i>Myocardial Infarction</i></p>		<p>DATE OF INTERMENT <i>Jan 17 1910</i></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 10

8164

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Charleston</b> <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH (Type or print) <b>Robert Sellwyn Inabinett</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 6, 1950</b>	
9. AGE (In years last birthday) <b>8</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.		IF UNDER 24 HRS. Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Reese Angus Inabinett</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Caddell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.2 Congenital Heart Disease - Ventricular Septal Defect - Status immediate postoperative.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>June 29</b> , 19 <b>58</b> , to <b>July 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 10</b> , 19 <b>58</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>7-10-58</b>							
ACTUAL SIGNATURE <b>Robert D. Bloodwell</b> M.D.				The Clinical Center The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>Robert D. Bloodwell, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>7/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Montg. Mem. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Montgomery</b> (State) <b>Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Md</b>				24a. REC'D BY REGISTRAR <b>JUL 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <b>Howard County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Ellicott City</b> 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Garden Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>R.</b> Last <b>Jenkins</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Estimator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cogswell Const. Co. Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William R. Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Margaret</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>218-03-7434</b>	
17. INFORMANT <b>Mrs. Srthur Gandy</b>		Address <b>9010 Linton St Silver Springs, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>1-2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral hemorrhage (old)</b> INTERVAL BETWEEN ONSET AND DEATH <b>7.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 25</b> , 19 <b>58</b> , to <b>July 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 8</b> , 19 <b>58</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b>		DATE SIGNED <b>7/11/58</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud, M.D.</b>		ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>7-11-58</b>	<b>Druid Ridge</b>	<b>Baltimore Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24. REC'D BY REGISTRAR <b>Jul 11 '58</b>	
ADDRESS <b>4107 Wilkens Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

County of Howard

City of Baltimore

Birth Date of Deceased

Age of Deceased

Place of Birth

Place of Death

Date of Death

Time of Death

Sex

Color

Occupation of Deceased

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Deceased

Signature of Witness

Signature of Coroner

Signature of Registrar

Signature of Coroner

Signature of Deceased

Signature of Witness

Signature of Coroner

Signature of Registrar

Signature of Deceased

Signature of Witness

Signature of Coroner

Signature of Registrar

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8166

## CERTIFICATE OF DEATH

08140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> ✓	
c. LENGTH OF STAY IN 1b <u>3 hours</u>		d. STREET ADDRESS <u>3100 St. Paul Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Hudson Johnson</u>	4. DATE OF DEATH <u>July 31 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1890</u>
9. AGE (In years last birthday) <u>68-62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Montgomery Dept. of Public Welfare</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. Frank Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Acute Myocardial infarction</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7.31.58</u> , 19 <u>58</u> , to <u>7.31.58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>A. D. Bonifant</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. D. Bonifant, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u> ADDRESS <u>Balto - 17, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 5 58</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

8167

## CERTIFICATE OF DEATH

Reg. Dist. No.

08141  
251

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MD. (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>1 HOUR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL, NMHC, BETHESDA, MD.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47X-3</b> ✓	
f. STREET ADDRESS <b>5217 FOURTH ST., NE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ross</b> Middle <b>Leonard</b> Last <b>JOHNSTON</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 2, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARMED FORCES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. MARINE CORPS</b>	
11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Lucian JOHNSTON</b>		14. MOTHER'S MAIDEN NAME <b>Julia SOUTHERN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>579-50-0571</b>	
17. INFORMANT <b>Helen C. JOHNSTON</b>		5217 FOURTH ST., N.E. <b>WASHINGTON, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastatic carcinoma</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c) <b>undetermined</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 13</b> , 19 <b>58</b> , to <b>JULY 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JULY 13</b> , 19 <b>58</b> , and that death occurred at <b>0955</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Troy</b>		ADDRESS (Street, city or town, state) <b>U. S. NAVAL HOSPITAL, NMHC</b> DATE SIGNED <b>7-14-58</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. TROY, CDR, MC, USN</b>		<b>BETHESDA, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-16-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOSEPH GAWLER'S &amp; SONS</b>		24. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BATHING

2020

2005

550

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs</u>		d. STREET ADDRESS <u>1424 Fenwick La</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1424 Fenwick La</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James John Kalesis</u> First <u>JOHN</u> Middle <u>XXXXXX</u> Last <u>Kalesis</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-13</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steam</u>	11. BIRTHPLACE (State or foreign country) <u>Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Kalesis</u>	
14. MOTHER'S MAIDEN NAME <u>Kris Larizon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>064-18-5848</u>		17. INFORMANT Address <u>Effie Kalesis (wife) 1424 Fenwick Lane Silver Spring Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-17-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Pumphrey</u>	

FOR STATE  
NORTH DAKOTA



THIS CERTIFICATE IS TO BE FILED IN THE  
OFFICE OF THE STATE ARCHIVIST  
AT BISMARCK, NORTH DAKOTA  
ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_  
A.D. 19\_\_\_\_

STATE OF NORTH DAKOTA  
BISMARCK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JAMES EARL RAY		35		M		W		C		M		H		C		C		JAN 4 1968		MEMPHIS, TENN		SHOOTING		HOMICIDE		JAMES EARL RAY		JAN 4 1968	
BIRTH DATE		BIRTH PLACE		MOTHER'S MAIDEN NAME		FATHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JAN 4 1933		MEMPHIS, TENN		JANIS MARIE RAY		JAMES EARL RAY		JAN 4 1958		MEMPHIS, TENN		H		C		C		JAN 4 1968		MEMPHIS, TENN		SHOOTING		HOMICIDE		JAMES EARL RAY		JAN 4 1968	
BIRTH DATE		BIRTH PLACE		MOTHER'S MAIDEN NAME		FATHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JAN 4 1933		MEMPHIS, TENN		JANIS MARIE RAY		JAMES EARL RAY		JAN 4 1958		MEMPHIS, TENN		H		C		C		JAN 4 1968		MEMPHIS, TENN		SHOOTING		HOMICIDE		JAMES EARL RAY		JAN 4 1968	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8169

## CERTIFICATE OF DEATH

08143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Portsmouth</b>			
c. LENGTH OF STAY IN 1b <b>11 days</b>				d. STREET ADDRESS <b>1705 McDaniel Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Martin</b> Middle <b>Vincent</b> Last <b>Kane</b>		4. DATE OF DEATH		Month <b>July</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1891</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick Kane</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Joyce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>228-20-6165</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Bunchpneumonia</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Leukemia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>June 27, 19 58</b> , to <b>July 8, 19 58</b> , that I last saw the deceased alive on <b>July 8, 19 58</b> , and that death occurred at <b>3:15 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leonard Garren</b>		M. D. <b>The Clinical Center</b>		DATE SIGNED <b>7/8/58</b>			
PHYSICIAN'S NAME (Type) <b>Leonard Garren, M. D.</b>		<b>National Institutes of Health</b>		<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>7-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Portsmouth, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1182

State of Virginia

County of Loudoun

City of Leesburg

Residence of Deceased

Deceased's Name

Age

Sex

Date of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Date of Burial

Place of Burial

Signature of Minister

County of Loudoun

City of Leesburg

Residence of Deceased

Deceased's Name

Age

Sex

The Clinical Center, Leesburg, Virginia

July 20, 1952

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

The Clinical Center, Leesburg, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08144

8077 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>		d. STREET ADDRESS <u>11025 Colesville Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Georgia Gray Keese</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25-1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Bourne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure &amp; Circulatory Collapse</u> <u>586x</u> DUE TO <u>possible portal hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with upper gastrointestinal bleeding</u> DUE TO <u>stenosis of sphincter of Oddi</u> (c) <u>causing obstructive jaundice</u> INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>few hours</u> <u>some months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Jaundice</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>42</u> , to <u>July 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>58</u> , and that death occurred at <u>9:34</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>934 Elmworth St. Silver Spring, Md.</u> DATE SIGNED <u>7-18-58</u>	
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MONOCACY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NO. 35

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8170 CERTIFICATE OF DEATH

Reg. Dist. No.

08145

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane San. 9310 Georgia</u>				d. STREET ADDRESS <u>401-Miller St. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED <u>SINGIE</u> First <u>VIRGINIA</u> Middle <u>Ann</u> Last <u>MENDRICK</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-74</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Posey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Groves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Bessie F. Trotter</u> Address <u>401-Miller St. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 25, 1958</u> , to <u>JULY 6, 1958</u> , that I last saw the deceased alive on <u>JULY 6, 1958</u> , and that death occurred at <u>10 55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Heurien Lourdes</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 NORWAY DR</u> DATE SIGNED <u>7/6/58</u>			
PHYSICIAN'S NAME (Type) <u>CHEVY CHASE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CHURCH CEM</u>		22d. LOCATION (City, town, or county) (State) <u>NANTJEMOY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WW CHAMBERS CO</u> ADDRESS <u>517-11th ST SE</u>				24a. REC'D BY REGISTRAR <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Archie</u>	



8171

## CERTIFICATE OF DEATH

08146  
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elmhurst</b> <b>51X-3</b> ✓	
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Jean</b> Last <b>KERR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 July 1944</b>
9. AGE (In years last birthday) <b>14</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert John KERR</b>		14. MOTHER'S MAIDEN NAME <b>Lois WILLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Father) Robert John Kerr</b>		Address <b>304 Kennebec St. Washington 21, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Lymphoblastic Leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 5</b> , 19 <b>58</b> , to <b>July 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 11</b> , 19 <b>58</b> , and that death occurred at <b>9:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NNMC</b> <b>7-11-58</b> ACTUAL SIGNATURE <b>L. G. Muth</b> M.D. PHYSICIAN'S NAME (Type) <b>R. G. MUTH LT MC USN</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-15-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. HINES FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>Washington, D.C.</b> <b>2901 14th St. NW,</b> DATE <b>JUL 15 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Over</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08147

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>23 Columbia Ave.</b>		d. STREET ADDRESS <b>23 Columbia Ave.</b>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last <b>George Judson King</b></div>		4. DATE OF DEATH <div style="text-align: center;">Month Day Year <b>July 4, 1958 19</b></div>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/19/1872</b>
9. AGE (in years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Writer &amp; Lecturer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not Available</b>		14. MOTHER'S MAIDEN NAME <b>Not Available</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>wife</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bladder Infection</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DATE SIGNED <b>7/4/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>July 9, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Search</b>		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8172

## CERTIFICATE OF DEATH

Reg. Dist. No.

08148

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN 1b <b>6 hrs 20 mins</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Naval Hospital Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District of Columbia</b> d. STREET ADDRESS <b>905 G. St. S.E.</b> <b>District of Columbia</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lloyd William Knott</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>July 26 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 Sept 1912</b>
9. AGE (In years last birthday) <b>45</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Percy Knott</b>		14. MOTHER'S MAIDEN NAME <b>Celia Dornan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1/2/32 to 10/15/53 557-50-7843</b>	
17. INFORMANT Address <b>Eleanor L. Knott 905 G. St. S.E., Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease with coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>26 July 19 58</b> to <b>1950 26 July 19 58</b> , that I last saw the deceased alive on <b>26 July 19 58</b> , and that death occurred at <b>1950</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.J. Jacoby</b> LCDR MC USN		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-27-58</b>	
PHYSICIAN'S NAME (Type) <b>W.J. Jacoby</b> LCDR MC USN		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-30-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Owens, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley Funeral Home</b> <b>Rhode Island Ave, N.E., Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Paul...</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—DEPARTMENT OF HEALTH—Baltimore, Md.

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8173

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>15 1/2</u> days		d. STREET ADDRESS <u>5601 Huntington Parkway</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Reinhard</u> Middle <u>Larsen</u> Last <u>Larsen</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>LARVIK, NORWAY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA (1905)</u>	
13. FATHER'S NAME <u>LARS LARSEN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>ARMY</u>		16. SOCIAL SECURITY NO. <u>216-12-8518A</u>	
17. INFORMANT <u>Ruth von der Fische</u> Address <u>Daughter</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic-cardiovascular new disease</u> DUE TO (c) <u>Chronic congestive heart failure</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 yrs</u> 4 months 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-11-</u> 19 <u>58</u> , to <u>7-15-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7-14-</u> 19 <u>58</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>3701 Connel Road</u> DATE SIGNED <u>7-15-58</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ocean View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Staten Island, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 16 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

2153

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and bleed-through from the reverse side.

NAME: *[illegible]*

DATE: *[illegible]*

PLACE: *[illegible]*

CAUSE: *[illegible]*

*[Additional illegible text and signatures follow]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 2 MdM C232 8/15/58 cci

8174

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County Gen. Hosp.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville - Rt. #2 Gaithersburg - Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1 100 W. / Montgomery Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Hobart</b> Last <b>Lawson</b>		4. DATE OF DEATH Month <b>7</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7.31.58</b>
9. AGE (In years last birthday) <b>0 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>1</b> Min <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jesse Lawson</b>		14. MOTHER'S MAIDEN NAME <b>Tommie Lou Miner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mother</b>		Address <b>100 W. Montg. Ave. Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (weight 2 lb. 761.5)</b> DUE TO <b>Jaundice</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature separation of placenta</b> (c) <b>Bleeding 5-6 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-31</b> , 19 <b>58</b> , to <b>7-31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-31</b> , 19 <b>58</b> , and that death occurred at <b>6:35</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.		ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b> DATE SIGNED <b>7.31.58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8-2-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manor</b>		22d. LOCATION (City, town, or county) (State) <b>Jonesville Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emmet C. Gaithersburg</b>		24a. REC'D BY REGISTRAR <b>Al. Search</b> DATE <b>AUG 4 '58</b>	
24b. REGISTRAR'S SIGNATURE			



8175

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>Brinklow</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elbin</b> Middle <b>Leishear</b> Last <b>Leishear</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. March 27, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas M. Leishear</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Molesworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) <b>Diabetes</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/11</b> , 19 <b>58</b> , to <b>7/15</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>7/15</b> , 19 <b>58</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sandy Sp. 7</b> <b>7/15/58</b>							
ACTUAL SIGNATURE <b>J. W. Bird</b>				M.D. <b>Sandy Sp. 7</b>			
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D., Sandy Spring, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodside Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brinklow, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray or Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 18 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leishear</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAIL STOP DEPARTMENT OF REGISTRATION

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08152

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.R.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>17713 Carroll Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lillie</u> Middle <u>Venable</u> Last <u>Lewis</u>				<b>4. DATE OF DEATH</b> Month <u>7</u> - Day <u>1</u> - Year <u>1958</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-1-85</u>	
<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired CLERK</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. GOVT.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>				<b>13. FATHER'S NAME</b> <u>Charles Lewis</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Motley</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>				<b>17. INFORMANT</b> <u>Previous Hospital Records</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Fracture of 1st &amp; 2nd cervical with rupture of cord</u> DUE TO (b) <u>Multiple fracture of ribs - fracture of pelvis + legs</u> DUE TO (c) <u>Auto injury</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Fracture of 10th Thoracic vertebra</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Sedestrian. Reported stepped in front of approaching truck</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>7-1-1958</u> Hour <u>4:04</u> <u>am</u> <u>p. m.</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u>				<b>20f. (City or town) (County) (State)</b> <u>Lingley Park P.G. Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosen</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosen</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>July 1-58</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>7-5-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GEO WASH MEM PK</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>PRINCE GEORGE'S COUNTY MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. CHAMBERS CO</u>				<b>ADDRESS</b> <u>1400 CHAPIN ST NW</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 7 '58</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. OCCUPATION [Faint text]		5. MARITAL STATUS [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]		9. PLACE OF DEATH [Faint text]	
10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF EXAMINER [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF WITNESS [Faint text]		15. SIGNATURE OF WITNESS [Faint text]	
16. SIGNATURE OF WITNESS [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF WITNESS [Faint text]		21. SIGNATURE OF WITNESS [Faint text]	
22. SIGNATURE OF WITNESS [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF WITNESS [Faint text]	
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91. SIGNATURE OF WITNESS [Faint text]		92. SIGNATURE OF WITNESS [Faint text]		93. SIGNATURE OF WITNESS [Faint text]	
94. SIGNATURE OF WITNESS [Faint text]		95. SIGNATURE OF WITNESS [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF WITNESS [Faint text]		99. SIGNATURE OF WITNESS [Faint text]	
100. SIGNATURE OF WITNESS [Faint text]		101. SIGNATURE OF WITNESS [Faint text]		102. SIGNATURE OF WITNESS [Faint text]	





8080

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>47X-3</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Martha</i> Last <i>Lindsay</i>				4. DATE OF DEATH Month <i>7</i> Day <i>13</i> Year <i>1958</i>			
5. SEX <i>fe</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-21-85</i>		9. AGE (In years lost birthday) <i>73</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Robert Lindsay</i>				14. MOTHER'S MAIDEN NAME <i>Susan Jane Boswell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Mrs. Susie B. Broadhurst, 1400 Holly St., N.W. Washington, D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Coronary occlusion</i> DUE TO (c) <i>Arteriosclerotic Heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>45 min.</i> <i>45 min.</i> <i>15 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Metastatic Carcinoma of Liver</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <i>July 12, 1958</i> , to <i>July 13, 1958</i> , that I last saw the deceased alive on <i>July 13, 1958</i> , and that death occurred at <i>1:22 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Russell B. Arnold</i>				ADDRESS (Street, city or town, state) <i>8801 Colesville Road Silver Spring, Md.</i>			
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold M.D.</i>				DATE SIGNED <i>July 13, 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7/16/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 16 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Redman</i>			

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		SUICIDE		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	

RECEIVED

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8081

## CERTIFICATE OF DEATH

08155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>31 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56	
e. STREET ADDRESS <u>9911 Tenbrook Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Louise</u> Last <u>Lockard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-15</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sears &amp; Roebuck - SS.</u>	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward M. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>IVY LOUISE LEWTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-9403</u>	
17. INFORMANT <u>Pt. &amp; old record. Same as above.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulo nephritis</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-23, 1958</u> , to <u>7-24, 1958</u> , that I last saw the deceased alive on <u>7-24, 1958</u> , and that death occurred at <u>3:20 p. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>927 Rushing St. Silver Spring Md.</u> DATE SIGNED <u>7-24-58</u>	
ACTUAL SIGNATURE <u>A. W. DAVIS</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. W. DAVIS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>  </u>			

CERTIFICATE OF DEATH

8081

Form No. 1

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of funeral home		14. Name of undertaker		15. Name of cemetery		16. Name of church	
17. Name of family		18. Name of next of kin		19. Name of executor		20. Name of administrator	
21. Name of guardian		22. Name of trustee		23. Name of agent		24. Name of attorney	
25. Name of witness		26. Name of witness		27. Name of witness		28. Name of witness	
29. Name of witness		30. Name of witness		31. Name of witness		32. Name of witness	
33. Name of witness		34. Name of witness		35. Name of witness		36. Name of witness	
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81. Name of witness		82. Name of witness		83. Name of witness		84. Name of witness	
85. Name of witness		86. Name of witness		87. Name of witness		88. Name of witness	
89. Name of witness		90. Name of witness		91. Name of witness		92. Name of witness	
93. Name of witness		94. Name of witness		95. Name of witness		96. Name of witness	
97. Name of witness		98. Name of witness		99. Name of witness		100. Name of witness	

RECEIVED  
JAN 10 1901  
BALTIMORE  
MAYOR'S OFFICE

10-10-1901

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8177

## CERTIFICATE OF DEATH

08156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MAINE</u> b. COUNTY <u>Cumberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 MINS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. STREET ADDRESS <u>45 DREW Road</u>			
3. NAME OF DECEASED (Type or print) <u>Henry Bertrand</u> First Middle Last				4. DATE OF DEATH <u>7/7/58</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1883</u> 74 yrs.	
9. AGE (In years last birthday) <u>74</u>		10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Retired -Salesman Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boston, MASS</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Lord</u>			
14. MOTHER'S MAIDEN NAME <u>Mary E. Mason</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. <u>5221 BRADLEY</u>				17. INFORMANT <u>John T. Lord</u> Address <u>Bethesda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-7-58</u> , to <u>7-7-58</u> , that I last saw the deceased alive on <u>7-7-58</u> , and that death occurred at <u>8:16</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jason Geiger, M.D.</u>				ADDRESS (Street, city or town, state) <u>431 Pershing Drive Silver Spring, Md.</u>			
DATE SIGNED <u>July 7, 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-Tr.</u>		<u>7/8/58</u>		<u>Mt. Pleasant</u>		<u>So. Portland, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

08157

Reg. Dist. No.

8178

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615.2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>4902 70th Place (Woodlawn)</u>	
3. NAME OF DECEASED (Type or print) First <u>Donn</u> Middle <u>Lawrence</u> Last <u>Lyle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1949</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Lyle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cleveland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-ventricular + Subarachnoid Hemorrhage</u> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myelocytic leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 10, 1958</u> , to <u>July 1, 1958</u> , that I last saw the deceased alive on <u>July 1, 1958</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter S. Mueller, M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Peter S. Mueller, M. D.</u>		DATE SIGNED <u>7/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Garden Sanitarium</u>			d. STREET ADDRESS <u>Washington D.C.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Marie</u> First Middle Last			4. DATE OF DEATH <u>July 28</u> 19 <u>58</u> Month Day Year		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1878</u> yrs. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>
13. FATHER'S NAME <u>Kalmars</u>			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			17. INFORMANT Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1958, to July 28, 1958, that I last saw the deceased alive on July 20, 1958, and that death occurred at 6:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Melvin W. Sandmeyer Jr. M.D. ADDRESS (Street, city or town, state) DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JULY 31, 1958</u>	<u>WASHINGTON NATIONAL CEM.</u>	<u>SUITLAND RD. PAGED CO MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE
<u>[Signature]</u>		<u>WASH DC</u>	<u>JUL 30 '58</u>
24b. REGISTRAR'S SIGNATURE			
<u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and must be filed within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08159

8082

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47 X-3	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie</u> <u>H</u> <u>Martin</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>10</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1880</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records - Washington San. &amp; Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> <u>330 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Aneurysm of Basilar Artery</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>58</u> , to <u>July 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9301 Coleville Rd., Silver Spring, Md. July 10, 58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

WILLIAM B. BROWN

WHITE

MALE

RESIDENT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF BIRTH

CAUSE OF BIRTH

8180

CERTIFICATE OF DEATH

Reg. Dist. No.

08160

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
c. LENGTH OF STAY IN 1b <b>55 1/2 days</b>		d. STREET ADDRESS <b>8205 Baltimore Boulevard</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Alberta</b> Last <b>Mason</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1919</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Bickle</b>		14. MOTHER'S MAIDEN NAME <b>Edna Klase</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-26-1671</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Vascular Hypertension</b> DUE TO (c) <b>Generalized Atherosclerosis, minute coronary occlusion</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>58</b> , to <b>July 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>58</b> , and that death occurred at <b>5:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Louis Gillespie, Jr.</b>		DATE SIGNED <b>7/21/58</b>	
PHYSICIAN'S NAME (Type) <b>Louis Gillespie, Jr., M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>7/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lewistown</b>		22d. LOCATION (City, town, or county) (State) <b>Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 24 '58</b>	
		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1782 - 1783

4 2 2 2 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8083

## CERTIFICATE OF DEATH

08161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. 20 D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>3150 Buena Vista Tr. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edwin</u> Last <u>Mauer</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-33</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>20</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSISTANT MANAGER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Woolworth Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alvin Mauer</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Marx</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes NAVY KOREAN</u>				16. SOCIAL SECURITY NO. <u>479-34.3468</u>			
17. INFORMANT <u>Wash Sant Hosp. Records.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Cerebro/Edema</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Viral Infection, overwhelming</u> DUE TO (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-18</u> , 19 <u>58</u> , to <u>7-20</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7-20-58</u> , 19 <u>58</u> , and that death occurred at <u>3:57 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Whitlock</u> M.D.				DATE SIGNED <u>7-20-58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES W. WHITLOCK</u>				<u>Takoma Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>July 24, 1958</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u> ADDRESS <u>254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 22 '58</u>			
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MEDICAL CERTIFICATION

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75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08162  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>13 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <b>Ohio</b> b. COUNTY <b>Youngstown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>947 Lakewood Ave.,</b> d. STREET ADDRESS <b>947 Lakewood Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jacob Joseph MAZY</b>		4. DATE OF DEATH Month Day Year <b>July 29 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 July 1937</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob MAZY</b>		14. MOTHER'S MAIDEN NAME <b>Helen J. HORBATH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes - Currently</b>		16. SOCIAL SECURITY NO. <b>278 36 3208</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain abscess</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Skull Fracture, Frontal, Compound, Comminuted.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident, Details Unknown</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:00 3-16 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>No Record</b>	20f. (City or town) (County) (State) <b>Oakland California</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart, MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>7-29-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Youngstown, Ohio</b>	
23. MEDICAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>W.W. Chambers, 1400 Chapin St., Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W.W. Chambers</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
NEW YORK STATE DEPARTMENT OF HEALTH - BATHKORE 18

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings. The form is oriented vertically and contains various checkboxes and lines for text entry.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

8182

Reg. Dist. No. 08463

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>3217 Omohundro Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cary</b> Middle <b>Grant</b> Last <b>MELLIEN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 June 1958</b>
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> IF UNDER 24 HRS. Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Dennis A. MELLIEN</b>		14. MOTHER'S MAIDEN NAME <b>Jacqueline Marie KROHN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>759.3 Situs Inversus with Severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cordiac anomalies</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>33 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 July</b> , 19 <b>58</b> , to <b>15 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>15 July</b> , 19 <b>58</b> , and that death occurred at <b>11:37 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kenneth W. Sell</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-16-58</b>	
PHYSICIAN'S NAME (Type) <b>Kenneth W. Sell, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lake Geneva, Wisconsin</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 18 '58</b>	
ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Seach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08164

## 8183 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Chile</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Santiago,</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		7 d. STREET ADDRESS <u>Moneda 1869</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Julio</u> Middle <u>(nmn)</u> Last <u>MIRANDA</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 May 1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aviator, L/COL Chilean Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chile</u>	12. CITIZEN OF WHAT COUNTRY? <u>Chile</u>
13. FATHER'S NAME <u>Martiniano MIRANDA</u>		14. MOTHER'S MAIDEN NAME <u>Maria AROS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>	
17. INFORMANT <u>Maria de MIRANDA</u>		Address <u>Silver Spring, 1919 East-West Hgwy.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oligodendroglioma, Right Cerebral hemisphere</u> <u>1930</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3 June</u> , 19 <u>58</u> , to <u>3 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 July</u> , 19 <u>58</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin M. Hemmness</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 7-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Edwin M. HEMNESS</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Tran-Burial</u>		22b. DATE THEREOF <u>Unknown</u>	22c. NAME OF CEMETERY OR CREMATORY <u>General Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Santiago, Chile</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Ramsey</u>		ADDRESS <u>557 Wisconsin Ave. Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overseer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08165

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC.</i> b. COUNTY <i>DC.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5051 New Hampshire Ave NW</i>	
c. LENGTH OF STAY IN 1b <i>13 days</i>		d. STREET ADDRESS <i>Wash., DC.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Sanatorium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ottie</i> Middle <i>Louise</i> Last <i>Mix</i>		4. DATE OF DEATH Month <i>July</i> Day <i>28</i> Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/10/85</i>
9. AGE (In years lost birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Gearhart</i>		14. MOTHER'S MAIDEN NAME <i>Maria Pensinger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>husband</i>	
17. INFORMANT <i>(Same as above)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>13 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 12, 1947</i> to <i>July 28, 1958</i> , that I last saw the deceased alive on <i>July 28, 1958</i> , and that death occurred at <i>5051</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dean H. Harding</i>		M.D. <i>113 Carroll St NW</i> DATE SIGNED <i>7/28/58</i>	
PHYSICIAN'S NAME (Type) <i>DEAN H. HARDING</i>		<i>Wash 12, DC</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>July 31, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington - Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Chatter</i>		24a. REC'D BY REGISTRAR <i>DC</i> 24b. REGISTRAR'S SIGNATURE <i>Alb...</i>	
ADDRESS <i>254 Carroll St NW</i>		DATE <i>JUL 30 '58</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08166

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>414 Hillmoor Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Combs</b> Last <b>Morford</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1883</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harris Combs</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Elizabeth Williams</b>		Address <b>Silver Spring, Md. 414 Hillmoor Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma (cervix)</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>12-15 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>1953</b> to <b>25 July, 1958</b> , that I last saw the deceased alive on <b>23 July, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>9036 Leesville Rd Silver Spring, Md.</b> DATE SIGNED <b>7/23/58</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>	22d. LOCATION (City, town, or county) <b>Washington, D.C.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>Jul 29 58</b> DATE	
ADDRESS <b>2901 14th St. N.W. Wash, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-101

Deceased's Name

Residence

Date of Death

Place of Death

Age

Sex

Signature of Registrar

Signature of Doctor

Signature of Coroner

Signature of Family

Signature of Witness

Signature of Minister

Signature of Registrar

Signature of Coroner

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

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Signature of Registrar

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8185 CERTIFICATE OF DEATH

08167

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>813 BONIFANT STREET</b>				d. STREET ADDRESS <b>813 BONIFANT STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>V.</b> Last <b>MULLEN</b>				4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1918</b>		9. AGE (In years last birthday) <b>40 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK BRINK</b>				14. MOTHER'S MAIDEN NAME <b>ALMA BORGEMENKE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>301-07-0300</b>		17. INFORMANT <b>ROBERT J. MULLEN 813 Bonifant Street,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>237x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RESPIRATORY PARALYSIS</b> DUE TO (c) <b>BRAIN TUMOR</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>1 MONTH</b> <b>3 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x NONE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <b>NONE</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NO ACCIDENT</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>NONE</b> P. M. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>	
20f. (City or town) <b>NONE</b>				20g. (County) <b>NONE</b>		20h. (State) <b>NONE</b>	
21. I certify that I attended the deceased from <b>1956</b> , 19____, to <b>7/3/58</b> , that I last saw the deceased alive on <b>7/3/58</b> , 19____, and that death occurred at <b>8:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1150 CONN AVE. NW WASHINGTON, D.C.</b> DATE SIGNED <b>7/3/58</b>							
ACTUAL SIGNATURE <b>John P. Gallagher</b>				M.D. <b>1150 CONN AVE. NW WASHINGTON, D.C.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN P. GALLAGHER</b>				<b>1150 Conn. Ave. N.W. Washington, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>Wash. D. C. 3821 14th. St. N.W.</b>		24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

## MARTLAND STATE DEPARTMENT OF HEALTH—Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No.

8186

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>70 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>RFD #1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Lynn</b> Last <b>Neeper</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1942</b>
9. AGE (In years last birthday) <b>16 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dorsey Neeper</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda Peters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic embryonal rhabdomyosarcoma</b> <b>197.3</b> DUE TO <b>to the lungs with respiratory insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Embryonal rhabdomyosarcoma of the left leg primary in the quadriceps femoris.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>6 1/2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23, 19 58</b> , to <b>July 2, 19 58</b> , that I last saw the deceased alive on <b>July 2, 19 58</b> , and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Peter S. Mueller, M.D.</b> <b>The Clinical Center</b> <b>7/3/58</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/6/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CURWENSVILLE, PENNSYLVANIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Archie</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Cause of Report	
Occupation of Report		Residence of Report		Manner of Report	
Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist	
Date of Examination		Place of Examination		Cause of Examination	
Occupation of Examination		Residence of Examination		Manner of Examination	
Signature of Medical Director		Signature of Health Officer		Signature of Sanitary Officer	
Date of Certification		Place of Certification		Cause of Certification	
Occupation of Certification		Residence of Certification		Manner of Certification	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Date of Registration		Place of Registration		Cause of Registration	
Occupation of Registration		Residence of Registration		Manner of Registration	
Signature of Medical Director		Signature of Health Officer		Signature of Sanitary Officer	
Date of Final Certification		Place of Final Certification		Cause of Final Certification	
Occupation of Final Certification		Residence of Final Certification		Manner of Final Certification	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14 Film G232 8-21-58 et

Reg. Dist. No. 08169

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 Lee Ave</b> <b>APT 105</b>		d. STREET ADDRESS <b>1 111 Lee Ave</b> <b>APT 105</b>	
3. NAME OF DECEASED (Type or print) First <b>Eula Mae</b> Middle <b>Nettles</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>femal</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1914</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Willie Nettles (husband)</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7/7/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>7-12-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Ernest James</b>		24a. RECEIVED BY REGISTRAR <b>JUL 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

#178



8187

## CERTIFICATE OF DEATH

Reg. Dist. No.

08170

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9315 Warren St.</i>		d. STREET ADDRESS <i>9315 Warren St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>NEUWIED</i> Last <i>NEUWIED</i>		4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 29, 1882</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Conn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James E. Lynn</i>		14. MOTHER'S MAIDEN NAME <i>Maria Kilmartin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Marothy Griffin</i>		Address <i>9315 Warren St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>8 weeks</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 15, 1958</i> , to <i>July 7, 1958</i> , that I last saw the deceased alive on <i>July 6, 1958</i> , and that death occurred at <i>8:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Joseph Kenrick</i>		ADDRESS (Street, city or town, state) <i>6450 Wisconsin Ave., Bethesda, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Dr. JOSEPH KENRICK</i>		DATE SIGNED <i>7/7/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8 July 58</i>	22b. DATE THROF	22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cem - Stanford Conn</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home 44 Main Ave NW</i>		24a. REC'D BY REGISTRAR <i>W. H. Beach</i>	
ADDRESS <i>Washington DC</i>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8188

Item 1 Film G231 7-11-58 et

## CERTIFICATE OF DEATH

08171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMORELAND HILLS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DC</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5210 Westwood Drive MD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HARRY SCOTT NEWMAN</b>				4. DATE OF DEATH <b>JULY 5 1958</b>			
5. SEX <b>M</b>		6. COLOR OF RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-09</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MGR OF BOWLING ALLEY</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>REHOBETH DELAWARE</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>HARRY SAMUEL NEWMAN</b>				14. MOTHER'S MAIDEN NAME <b>ANNA ARMSTRONG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>577 20 8612</b>			
17. INFORMANT <b>Mrs Lucille OWEN</b>				Address <b>5210 Westwood Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 4, 1958</b> to <b>July 4, 1958</b> that I last saw the deceased alive on <b>July 4, 1958</b> , and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5210 Westwood Drive Westmoreland Hills, Md.</b> DATE SIGNED <b>July 5 58</b>							
ACTUAL SIGNATURE <b>Robert F. Owen</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Robert F. Owen</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/8/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Arlington, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

8136

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

MARRIAGE

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

MARRIAGE

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

MARRIAGE

EDUCATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

8189

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>12 hr. 50 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Thomas</b> Last <b>Nicholson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/12/77</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>Annie E. Musgrove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mamie M. Nicholson</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO <b>Dehydration "heat stroke"</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis Generalized</b> DUE TO (c) <b>330</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>1 wk.</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/23, 1958</b> , to <b>7/24, 1958</b> , that I last saw the deceased alive on <b>7/24, 1958</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b>		DATE SIGNED <b>7/25/58</b>	
PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M.D.</b>				<b>Sandy Spring, Maryland</b>			
22a. BURIAL, CREMATION, REINTERMENT (Type) <b>Burial</b>		22b. DATE THEREOF <b>July 27</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Olney Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne Barber</b>				ADDRESS <b>Laytonville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 30 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08173

8086 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 wks</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				47 x -3			
d. NAME OF DECEASED (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>				d. STREET ADDRESS <u>1201 Hamilton St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MINNIE LEE NICHOLSON</u>				4. DATE OF DEATH <u>7-29-1958</u>			
5. SEX <u>F</u>				6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8/25/186</u>			
9. AGE (In years last birthday) <u>71</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aut.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>James W. Carlisle</u>				14. MOTHER'S MAIDEN NAME <u>Ann Virginia Leapley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Record</u>			
17. INFORMANT <u>Hospital Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast - metastases</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 27, 1958</u> to <u>July 28, 1958</u> , that I last saw the deceased alive on <u>July 28, 1958</u> , and that death occurred at <u>2:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>927 Parkway Dr. Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>A.W. DAVIS</u>				DATE SIGNED <u>7-29-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>7/31/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>JUL 30 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

2006 CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>710 Mapleton Dr</u>			d. STREET ADDRESS <u>710 Mapleton Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Samuel Russell Nicholson</u>			4. DATE OF DEATH <u>July 19 1958</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-2-1904</u>		9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John T. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann Daymude</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW 2</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-03-6638</u>		17. INFORMANT <u>Viola Nicholson (wife)</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laryngeal Obstruction</u> DUE TO (c) <u>Fracture of Larynx</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u> <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> <u>pm</u> <u>7-19 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-20-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boys Church Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Boys, Maryland</u>		(State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			ADDRESS <u>Bethesda, Maryland</u>		
24a. REC'D BY REGISTRAR <u>  </u>			24b. REGISTRAR'S SIGNATURE <u>  </u>		
DATE <u>JUL 22 '58</u>					



8087

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>Immediate hosp</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hosp</u>				d. STREET ADDRESS <u>8627 Flower Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Joseph</u> Last <u>Nathan</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-90</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. Amer</u>			
13. FATHER'S NAME <u>Anthony Nathan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Maurer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>PT Hosp. Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cardiac Decompensation</u> DUE TO (c) <u>" Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 wks</u> <u>1 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/12/58</u> 19 <u>58</u> , to <u>7/10</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7/10</u> 19 <u>58</u> , and that death occurred at <u>11:35 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10,116 Riggs Road, Adelphia, Md.</u> DATE SIGNED <u>7-10-58</u>							
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Raymond O West</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 14 58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8190

# CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> <b>Montgomery</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville..</b> d. STREET ADDRESS <b>/</b>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Garfield</b>		<b>4. DATE OF DEATH</b> <b>July 26, 1958</b>									
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>C</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 26 1881</b>								
<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>									
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Unknown</b>									
<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)									
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Ammons Nursing Home, Gaithersburg, Md.</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Mitral Stenosis</b> DUE TO (c) <b>Cardiac Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphasema. Chronic Bronchitis. Anemia.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that I attended the deceased from June 8, 1953, to July 26, 1958, that I last saw the deceased alive on July 26, 1958, and that death occurred at 6:10 A.M. from the causes and on the date stated above.</b>											
<b>ACTUAL SIGNATURE</b> <b>Webster Sewell</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>Norbeck</b> <b>DATE SIGNED</b> <b>7/29/58</b>									
<b>PHYSICIAN'S NAME (Type)</b> <b>Webster Sewell, M.D.</b>		<b>Rt. 1 Silver Spring, Md.</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>7/29/58</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lincoln Park..</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>Rockville, Md.</b>								
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert L. Snowden</b>		<b>ADDRESS</b> <b>Rockville, Md.</b>	<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AUG 6 '58</b>								
<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. Leach</b>											

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

ARIZONA STATE DEPARTMENT OF HEALTH—TALLAHASSEE, FL

08177

## 8191 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>15 min.</u>		d. STREET ADDRESS <u>14815 Montgomery Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John King O'Shaughnessy</u>		4. DATE OF DEATH Month Day Year <u>July 28 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10 4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Urban Marguerite</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frances O'Shaughnessy</u>		Address <u>4815 Montgomery Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma lung</u> DUE TO (c) <u>3+ years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adrenal insufficiency - Metabolic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> to <u>July 28, 1958</u> , that I last saw the deceased alive on <u>July 28, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St</u> DATE SIGNED <u>7-28-58</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.

*Robertson, James*  
*1911*

*Robertson, James*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10 Film 231 7-21-58 et

08178

8192

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>94 1/4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Claude</b> Last <b>Owen</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> , 19 <b>58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 17, 1884</b>	
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Owen</b>				14. MOTHER'S MAIDEN NAME <b>Patricia Kelley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic malignant carcinoid in liver</b> DUE TO (c) <b>Malignant carcinoid primary in ileum</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b> <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic-cardiovascular disease; chronic urinary tract infect.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 14, 1958</b> , to <b>July 17, 1958</b> , that I last saw the deceased alive on <b>July 17, 1958</b> , and that death occurred at <b>11:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman R. Gevirtz</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Norman R. Gevirtz, M. D.</b>				DATE SIGNED <b>7-18-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>7/22/58</b>		<b>Wash. National</b>		<b>Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>				ADDRESS <b>1400 Chapin St. NW</b> <b>Wash. D.C.</b>			
24a. REC'D BY REGISTRAR <b>JUL 22 58</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a life burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
John Doe		Male		45		Jan 1, 1900		New York		New York		Heart Disease		Jan 15, 1945		10:00 AM		New York		John Doe, M.D.		John Doe, Registrar			
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Certified by		Date of Certification		Place of Certification		Signature of Physician		Signature of Registrar			
Teacher		Married		White		Catholic		High School		None		Natural		John Doe, M.D.		Jan 15, 1945		New York		John Doe, M.D.		John Doe, Registrar			
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Certification		Place of Certification		Signature of Physician		Signature of Registrar		Date of Certification		Place of Certification		Signature of Physician		Signature of Registrar	
Jan 15, 1945		10:00 AM		New York		John Doe, M.D.		John Doe, Registrar		Jan 15, 1945		New York		John Doe, M.D.		John Doe, Registrar		Jan 15, 1945		New York		John Doe, M.D.		John Doe, Registrar	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8193 CERTIFICATE OF DEATH

Reg. Dist. No.

08179

1. PLACE OF DEATH o. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Pineales</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Rocks Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>48x-3</u>	
3. NAME OF DECEASED (Type or print) <u>Clara Helen Owens</u> First Middle Last		4. DATE OF DEATH <u>July 26</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24 '98</u> 9. AGE (In years last birthday) <u>60</u> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Edward Wells</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Virginia Wells</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Helen Reed. RFD #2 Gaithersburg Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast metastases</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10 June 1958</u> to <u>26 July 1958</u> , that I last saw the deceased alive on <u>24 July 1958</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman Chiazanzini</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md Center</u> DATE SIGNED <u>7/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Herman Chiazanzini</u>		<u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer C. Feltner Gaithersburg Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>W. Beach</u> DATE <u>JUL 28 '58</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8194

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural-Gaithersburg,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Quince Orchard Road</b>		d. STREET ADDRESS <b>1 Quince Orchard Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>T</b> Last <b>PALMER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	9. AGE (In years lost birthday) yrs. <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Benjamin Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>218-03-0453</b>	
17. INFORMANT <b>Ethelyn M. Palmer-same as 2</b>		Address <b>Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>UREMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute glomerular nephritis</b> (c) <b>arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 month</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>19</b> p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>50</b> , to <b>July 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 8</b> , 19 <b>58</b> , and that death occurred at <b>2:45</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Fawcett</b>		ADDRESS (Street, city or town, state) <b>P.O. Bagel, Md</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT</b>		DATE SIGNED <b>July 9, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>ROBERT</b>		2. SEX <b>Male</b>		3. AGE <b>35</b>	
4. OCCUPATION <b>None</b>		5. COLOR <b>White</b>		6. BIRTH DATE <b>July 14, 1883</b>	
7. PLACE OF BIRTH <b>Poland, Nebraska</b>		8. MARITAL STATUS <b>Single</b>		9. PLACE OF DEATH <b>Poland, Nebraska</b>	
10. CAUSE OF DEATH <b>Unknown</b>		11. MANNER OF DEATH <b>Accidental</b>		12. DATE OF DEATH <b>July 14, 1918</b>	
13. SIGNATURE OF PHYSICIAN <b>W. H. H. H.</b>		14. SIGNATURE OF WITNESSES <b>W. H. H. H.</b>		15. SIGNATURE OF DECEASED <b>W. H. H. H.</b>	
16. SIGNATURE OF REGISTRAR <b>W. H. H. H.</b>		17. SIGNATURE OF CLERK <b>W. H. H. H.</b>		18. SIGNATURE OF JURY <b>W. H. H. H.</b>	
19. SIGNATURE OF JUDGE <b>W. H. H. H.</b>		20. SIGNATURE OF SHERIFF <b>W. H. H. H.</b>		21. SIGNATURE OF CONSTABLE <b>W. H. H. H.</b>	
22. SIGNATURE OF TOWNSHIP CLERK <b>W. H. H. H.</b>		23. SIGNATURE OF COUNTY CLERK <b>W. H. H. H.</b>		24. SIGNATURE OF STATE CLERK <b>W. H. H. H.</b>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

08181

8195

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				1 d. STREET ADDRESS <u>5521 Dorsey Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cassius</u> Middle <u>Charles</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>78</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tenleytown, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Parker</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grandson</u> <u>Cassius Dorsey</u>		Address <u>Washington, D.C.</u> <u>1353 Montique Street,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>paralytic illness</u> <u>570.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uremia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>58</u> , to <u>July 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Cornwell</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fisherman Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lincoln Park. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08182

8088

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 hr.</u>		d. STREET ADDRESS <u>10325 Parkman Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore</u> First <u>Graham</u> Middle <u>Parkman</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Manager, United Publishing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Henry C. Parkman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or date of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>597-40-6114</u>	
17. INFORMANT <u>Hospital Records &amp; wife of deceased.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>16</u> , to <u>28 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>28 July</u> , 19 <u>58</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. B. Queen</u>		M.D. <u>7112 Willow Ave</u> <u>28 July</u>	
PHYSICIAN'S NAME (Type) <u>J. B. Queen</u>		<u>Takoma Park Md</u> <u>1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRACE EPISCOPAL CHURCH CEMETERY, MONTGOMERY COUNTY, MD.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 1</u> '58		24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

6032

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Place of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Office of registration: _____</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8196 CERTIFICATE OF DEATH

Reg. Dist. No.

08183

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
c. LENGTH OF STAY IN 1b <b>79 days</b>		d. STREET ADDRESS <b>3262 S. Glebe Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Morrison</b> Last <b>PARR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Dec. 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry MORRISON</b>		14. MOTHER'S MAIDEN NAME <b>Alice MAC PARLANE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Son) Ralph S. PARR, JR, Tyndall Air Force Base,</b>		Address <b>Panama City, Fla.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>162.1 carcinoma Bronchogenic left</b> DUE TO (b) <b>one year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 May</b> , 19 <b>58</b> , to <b>24 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>23 July</b> , 19 <b>58</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Larry J. Hines</b> <b>U.S. Naval Hospital, Bethesda, Md. 7-25-58</b> ACTUAL SIGNATURE M.D. <b>Larry J. Hines</b> PHYSICIAN'S NAME (Type) <b>Larry J. Hines, LCDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Bingham</b>		24a. REC'D BY REGISTRAR <b>JUL 28 '58</b>	
ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of witness: _____</p>	
<p>11. Signature of registrar: _____</p>	
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<p>70. Signature of registrar: _____</p>	
<p>71. Signature of registrar: _____</p>	
<p>72. Signature of registrar: _____</p>	
<p>73. Signature of registrar: _____</p>	
<p>74. Signature of registrar: _____</p>	
<p>75. Signature of registrar: _____</p>	
<p>76. Signature of registrar: _____</p>	
<p>77. Signature of registrar: _____</p>	
<p>78. Signature of registrar: _____</p>	
<p>79. Signature of registrar: _____</p>	
<p>80. Signature of registrar: _____</p>	
<p>81. Signature of registrar: _____</p>	
<p>82. Signature of registrar: _____</p>	
<p>83. Signature of registrar: _____</p>	
<p>84. Signature of registrar: _____</p>	
<p>85. Signature of registrar: _____</p>	
<p>86. Signature of registrar: _____</p>	
<p>87. Signature of registrar: _____</p>	
<p>88. Signature of registrar: _____</p>	
<p>89. Signature of registrar: _____</p>	
<p>90. Signature of registrar: _____</p>	
<p>91. Signature of registrar: _____</p>	
<p>92. Signature of registrar: _____</p>	
<p>93. Signature of registrar: _____</p>	
<p>94. Signature of registrar: _____</p>	
<p>95. Signature of registrar: _____</p>	
<p>96. Signature of registrar: _____</p>	
<p>97. Signature of registrar: _____</p>	
<p>98. Signature of registrar: _____</p>	
<p>99. Signature of registrar: _____</p>	
<p>100. Signature of registrar: _____</p>	

08184

8197

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Edingboro Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Gerald</u> Last <u>Pellau</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1958</u>	
9. AGE (In years last birthday) <u>18</u>		IF UNDER 1 YEAR Months <u>18</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u>18</u> Mins <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Robert Gerald Pellau</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>769.1 Hyaline Membrane Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyperinsulinism</u> DUE TO (c) <u>Diabetic Mother</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-2</u> , 19 <u>58</u> , to <u>7-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>615 W. Montgomery Ave. Rockville, Md. 7/3/58</u>			
PHYSICIAN'S NAME (Type) <u>W. G. Hall, M.D.</u>				615 W. Montg. Ave. Rock. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Seaver</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8198 CERTIFICATE OF DEATH

08185

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Michael PERRY</b>		4. DATE OF DEATH Month Day Year <b>July 10 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 June 1958</b>
9. AGE (In years last birthday) yrs. <b>12</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Robert PERRY</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ayers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Father) Richard R. Perry (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b>			
763.5 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Pneumonia, Bilateral</b>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>Immaturity</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 June 19 58</b> , to <b>10 July 19 58</b> , that I lost saw the deceased alive on <b>10 July 19 58</b> , and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adam G. Thorp, Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-11-58</b>	
PHYSICIAN'S NAME (Type) <b>Adam G. Thorp, Jr. LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-15-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Chambers &amp; Co.</b>		ADDRESS <b>Washington, D.C.</b>	
Chambers Funeral Home, 517 11th St., S.E.		6. REC'D BY REGISTRAR DATE <b>JUL 15 '58</b>	
		24. REGISTRAR'S SIGNATURE <b>W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051252XU1

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Date of Burial		Place of Burial		Name of Minister	
Name of Physician		Name of Undertaker		Name of Coroner	
Signature of Registrar		Signature of Deceased		Signature of Witness	
Date of Registration		Place of Registration		Name of Registrar	
Name of Hospital		Name of Doctor		Name of Nurse	
Name of Family		Name of Friends		Name of Neighbors	
Name of Clergy		Name of Musician		Name of Organist	
Name of Flowers		Name of Casket		Name of Coffin	
Name of Burial		Name of Vault		Name of Monument	
Name of Grave		Name of Plot		Name of Section	
Name of Cemetery		Name of Church		Name of Parish	
Name of Town		Name of County		Name of State	
Name of Country		Name of Continent		Name of World	
Name of Universe		Name of Cosmos		Name of Galaxy	
Name of Solar System		Name of Planet		Name of Moon	
Name of Star		Name of Constellation		Name of Zodiac	
Name of Season		Name of Month		Name of Day	
Name of Year		Name of Decade		Name of Century	
Name of Millennium		Name of Era		Name of Age	
Name of Epoch		Name of Period		Name of Epoch	
Name of Cycle		Name of Phase		Name of Stage	
Name of Process		Name of Action		Name of Event	
Name of Occurrence		Name of Incident		Name of Episode	
Name of Episode		Name of Chapter		Name of Volume	
Name of Part		Name of Section		Name of Page	
Name of Line		Name of Word		Name of Letter	
Name of Character		Name of Symbol		Name of Mark	
Name of Sign		Name of Flag		Name of Banner	
Name of Emblem		Name of Seal		Name of Stamp	
Name of Mark		Name of Brand		Name of Label	
Name of Tag		Name of Ticket		Name of Card	
Name of Paper		Name of Sheet		Name of Page	
Name of Book		Name of Volume		Name of Part	
Name of Series		Name of Set		Name of Collection	
Name of Library		Name of Museum		Name of Gallery	
Name of Theater		Name of Stage		Name of Screen	
Name of Film		Name of Picture		Name of Image	
Name of Photograph		Name of Picture		Name of Image	
Name of Drawing		Name of Sketch		Name of Illustration	
Name of Painting		Name of Canvas		Name of Picture	
Name of Sculpture		Name of Statue		Name of Image	
Name of Monument		Name of Structure		Name of Building	
Name of House		Name of Home		Name of Residence	
Name of Apartment		Name of Flat		Name of Dwelling	
Name of Office		Name of Room		Name of Space	
Name of Hall		Name of Corridor		Name of Passage	
Name of Staircase		Name of Ladder		Name of Escalator	
Name of Elevator		Name of Lift		Name of Hoist	
Name of Bridge		Name of Span		Name of Structure	
Name of Road		Name of Highway		Name of Avenue	
Name of Street		Name of Lane		Name of Way	
Name of Path		Name of Trail		Name of Route	
Name of Track		Name of Road		Name of Way	
Name of River		Name of Stream		Name of Waterway	
Name of Lake		Name of Pond		Name of Body of Water	
Name of Sea		Name of Ocean		Name of Waterway	
Name of Bay		Name of Harbor		Name of Port	
Name of Canal		Name of Lock		Name of Waterway	
Name of Tunnel		Name of Bridge		Name of Structure	
Name of Viaduct		Name of Overpass		Name of Underpass	
Name of Subway		Name of Metro		Name of Transit	
Name of Train		Name of Car		Name of Vehicle	
Name of Bus		Name of Truck		Name of Vehicle	
Name of Ship		Name of Boat		Name of Vessel	
Name of Plane		Name of Aircraft		Name of Vehicle	
Name of Rocket		Name of Spacecraft		Name of Vehicle	
Name of Satellite		Name of Orbiter		Name of Vehicle	
Name of Station		Name of Base		Name of Facility	
Name of Office		Name of Room		Name of Space	
Name of Hall		Name of Corridor		Name of Passage	
Name of Staircase		Name of Ladder		Name of Escalator	
Name of Elevator		Name of Lift		Name of Hoist	
Name of Bridge		Name of Span		Name of Structure	
Name of Road		Name of Highway		Name of Avenue	
Name of Street		Name of Lane		Name of Way	
Name of Path		Name of Trail		Name of Route	
Name of Track		Name of Road		Name of Way	
Name of River		Name of Stream		Name of Waterway	
Name of Lake		Name of Pond		Name of Body of Water	
Name of Sea		Name of Ocean		Name of Waterway	
Name of Bay		Name of Harbor		Name of Port	
Name of Canal		Name of Lock		Name of Waterway	
Name of Tunnel		Name of Bridge		Name of Structure	
Name of Viaduct		Name of Overpass		Name of Underpass	
Name of Subway		Name of Metro		Name of Transit	
Name of Train		Name of Car		Name of Vehicle	
Name of Bus		Name of Truck		Name of Vehicle	
Name of Ship		Name of Boat		Name of Vessel	
Name of Plane		Name of Aircraft		Name of Vehicle	
Name of Rocket		Name of Spacecraft		Name of Vehicle	
Name of Satellite		Name of Orbiter		Name of Vehicle	
Name of Station		Name of Base		Name of Facility	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8089

## CERTIFICATE OF DEATH

Reg. Dist. No. 08186

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				e. STREET ADDRESS <u>17520 Holly Ave</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last <u>G (i.o) Pool Sr.</u>				4. DATE OF DEATH <u>July 6</u> 19 <u>58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/16</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Publications &amp; Chief of Committee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Pool Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW2</u>				16. SOCIAL SECURITY NO. <u>292-01-9997</u>			
17. INFORMANT <u>Hosp records</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Multiple Myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 Months.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 21</u> , 19 <u>58</u> , to <u>July 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>58</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Coleman</u> M.D.				ADDRESS (Street, city or town, state) <u>113 Carroll St. N.W. Wash. D.C.</u>			
DATE SIGNED <u>7/6/58</u>							
18. NAME (Type) <u>James R. Coleman, M.D.</u>				113 Carroll St. N. W. Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			



8199

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Peggy</b> Middle <b>May</b> Last <b>PRYCE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 January 1913</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>England</b>							
13. FATHER'S NAME <b>Richard WALKER</b>				14. MOTHER'S MAIDEN NAME <b>Edith HACELBLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>(Husband) Roland F. PRYCE Rt. 17 Paramus, N.J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0</b> DUE TO <b>Alkemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 July</b> , 19 <b>58</b> , to <b>23 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>23 July</b> , 19 <b>58</b> , and that death occurred at <b>11:00P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. G. Muth</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-24-58</b>			
PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-26-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Birch and Sons, 3034 "M" St., N.W. Wash. D. C.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8200

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seaside</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>15203 Saratoga Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Edward Quillian</i>				4. DATE OF DEATH Month Day Year <i>July 13 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 13, 1908</i>		9. AGE (In years, last birthday) <i>50</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Henry Quillian</i>				14. MOTHER'S MAIDEN NAME <i>Louise Trier</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>577-01-0601</i>		17. INFORMANT <i>Kathleen Quillian - Above Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 hours</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 13, 1958</i> to <i>present</i> , that I last saw the deceased alive on <i>July 13, 1958</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C.P. Ryland</i>				ADDRESS (Street, city or town, state) <i>4400-49 St NW Washington 16 DC</i>		DATE SIGNED <i>7-13-58</i>	
PHYSICIAN'S NAME (Type) <i>C.P. RYLAND</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/16/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. H. Jones Co.</i>				24a. REC'D BY REGISTRAR <i>15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1900

DEATH

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF UNDERTAKER

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

NAME OF INTERMENT

8201

## CERTIFICATE OF DEATH

Items 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20-58 et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>7305-Hilton Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Minnie Wall Reed</i>		4. DATE OF DEATH <i>July 12 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 8, 1876</i>
9. AGE (In years last birthday) <i>81 yrs.</i>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>clerical</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Andrew Wall</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Bent</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>7305-Hilton Ave</i>	
17. INFORMANT <i>Stanley Reed</i>		Address <i>7305-Hilton Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>Hypertension &amp; arteriosclerosis</i> DUE TO (c) <i>?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2 10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Granulocytopenia - cause undetermined</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 30, 1958</i> , to <i>July 12, 1958</i> , that I last saw the deceased alive on <i>July 11, 1958</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip H. Warner</i>		ADDRESS (Street, city or town, state) <i>7722 Penn. Ave.</i>	
PHYSICIAN'S NAME (Type) <i>Cheryl Chase, Md.</i>		DATE SIGNED <i>7-12-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 14, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Waller</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24a. REC'D BY REGISTRAR <i>Jul 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Cheryl Chase</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8090**  
**CERTIFICATE OF DEATH**

08190

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kalls Nursing Home</u>		d. STREET ADDRESS <u>4507 Argyle Terrace, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah Elizabeth</u> Middle <u>Reynolds</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph H. Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Lucy M. Goss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>myrtle Reynolds</u>		Address <u>4507 Argyle Ter. NW Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 29, 1958</u> to <u>July 30, 1958</u> , that I last saw the deceased alive on <u>July 29, 1958</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u> DATE SIGNED <u>7-30-58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Tal Sama Park mcd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	



8202

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 13 da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Ensign</b> Last <b>RICHARDSON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-2-93</b>	
9. AGE (In years lost birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineering (mechanical)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Irving RICHARDSON</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ann ENSIGN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WWI</b>		17. INFORMANT <b>(Wife) Ural L. RICHARDSON</b>		Address <b>(Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralysis Agitans</b> <b>350 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3 July</b> , 19 <b>58</b> , to <b>4 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3 July</b> , 19 <b>58</b> , and that death occurred at <b>1225 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. E. GORSUCH LT MC USN</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, Bethesda, Md. 7-4-58</b>			
PHYSICIAN'S NAME (Type) <b>G. E. GORSUCH LT MC USN</b>				U. S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Humphrey</b>				ADDRESS <b>8434 Georgia Ave., Silver Spring, Md.</b>			
24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>				24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>	
<p>6. Date of death: _____</p>	
<p>7. Place of death: _____</p>	
<p>8. Cause of death: _____</p>	
<p>9. Signature of physician: _____</p>	
<p>10. Signature of registrar: _____</p>	
<p>11. Signature of informant: _____</p>	
<p>12. Signature of witness: _____</p>	
<p>13. Signature of registrar: _____</p>	
<p>14. Signature of informant: _____</p>	
<p>15. Signature of witness: _____</p>	
<p>16. Signature of registrar: _____</p>	
<p>17. Signature of informant: _____</p>	
<p>18. Signature of witness: _____</p>	
<p>19. Signature of registrar: _____</p>	
<p>20. Signature of informant: _____</p>	
<p>21. Signature of witness: _____</p>	
<p>22. Signature of registrar: _____</p>	
<p>23. Signature of informant: _____</p>	
<p>24. Signature of witness: _____</p>	
<p>25. Signature of registrar: _____</p>	
<p>26. Signature of informant: _____</p>	
<p>27. Signature of witness: _____</p>	
<p>28. Signature of registrar: _____</p>	
<p>29. Signature of informant: _____</p>	
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<p>31. Signature of registrar: _____</p>	
<p>32. Signature of informant: _____</p>	
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<p>34. Signature of registrar: _____</p>	
<p>35. Signature of informant: _____</p>	
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<p>40. Signature of registrar: _____</p>	
<p>41. Signature of informant: _____</p>	
<p>42. Signature of witness: _____</p>	
<p>43. Signature of registrar: _____</p>	
<p>44. Signature of informant: _____</p>	
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<p>78. Signature of witness: _____</p>	
<p>79. Signature of registrar: _____</p>	
<p>80. Signature of informant: _____</p>	
<p>81. Signature of witness: _____</p>	
<p>82. Signature of registrar: _____</p>	
<p>83. Signature of informant: _____</p>	
<p>84. Signature of witness: _____</p>	
<p>85. Signature of registrar: _____</p>	
<p>86. Signature of informant: _____</p>	
<p>87. Signature of witness: _____</p>	
<p>88. Signature of registrar: _____</p>	
<p>89. Signature of informant: _____</p>	
<p>90. Signature of witness: _____</p>	
<p>91. Signature of registrar: _____</p>	
<p>92. Signature of informant: _____</p>	
<p>93. Signature of witness: _____</p>	
<p>94. Signature of registrar: _____</p>	
<p>95. Signature of informant: _____</p>	
<p>96. Signature of witness: _____</p>	
<p>97. Signature of registrar: _____</p>	
<p>98. Signature of informant: _____</p>	
<p>99. Signature of witness: _____</p>	
<p>100. Signature of registrar: _____</p>	

8203

## CERTIFICATE OF DEATH

08192

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 1615.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>7908 Muncy Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jeanette</b> Middle <b>(none)</b> Last <b>Rinaldo</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 21, 1949</b>
9. AGE (In years lost birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Rinaldo</b>		14. MOTHER'S MAIDEN NAME <b>Margaret A. Conway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Supra-valvular aortic stenosis</b> DUE TO (c) <b>8 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>40</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>July 6, 1958</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 6, 1958</b> , to <b>July 16, 1958</b> , that I last saw the deceased alive on <b>July 16, 1958</b> and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William M. Pfaff</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William M. Pfaff, M.D.</b>		DATE SIGNED <b>7/16/58</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/19/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemteery</b>
22d. LOCATION (City, town, or county) <b>Washington D. C</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>	
24a. REC'D BY REGISTRAR <b>21 58</b>		24b. REGISTRAR'S SIGNATURE <b>Reese</b>	

MEDICAL CERTIFICATION

2

50

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8103

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Physician's Signature [Illegible]		Registrar's Signature [Illegible]	
Date of Declaration [Illegible]		City or Town [Illegible]	
County [Illegible]		State [Illegible]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS <u>18712 Colesville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8712 Colesville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie Elizabeth Rose</u>		4. DATE OF DEATH <u>July 15 - 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-97</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Woods</u>		14. MOTHER'S MAIDEN NAME <u>Emma Laws</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>WM Geo. Rose Sr - husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>	

DATE SIGNED

7-15-58

FOR THE  
HEALTH DEPT.

NAME OF DECEASED

AGE AT DEATH

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF BURIAL PLACE

DATE OF BURIAL

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF JURY

NAME OF JURY

NAME OF JURY

NAME OF JURY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08195

8205

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 MO-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy 10X-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Grove Chronic Hosp-</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>George W. Runkles</u>			4. DATE OF DEATH <u>July 15 1958</u>		
5. SEX <u>M-</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31 1859</u>	9. AGE (In years last birthday) <u>98</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Basil Runkles</u>		
14. MOTHER'S MAIDEN NAME <u>Ellen Mentzer</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>NOTIE</u>			17. INFORMANT <u>Mrs. Wm F. Wagner</u> address <u>Mt. Airy Md - nephew</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>5 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>July 15, 1958</u> , that I last saw the deceased alive on <u>7/1</u> , 19 <u>58</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Sandy Spring</u>			ADDRESS (Street, city or town, state) <u>Sandy Spring Md.</u> DATE SIGNED <u>7/15/58</u>		
PHYSICIAN'S NAME (Type) <u>Dr. J. W. Bird</u>			DATE <u>July 17 '58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C M Walz Jr.</u> ADDRESS <u>Winfield, Md.</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08196

8206

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN TB <b>3 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,611 Bushey Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAVID (NMI) SAMSON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/85</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Tube Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Samson</b>		14. MOTHER'S MAIDEN NAME <b>Anne ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>011-03-1902</b>	
17. INFORMANT <b>Mrs. Mildred S. Olson, 12,611 Bushey Drive Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Myocardial Disease 2) Nephrosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12, 1955</b> to <b>July 5, 1958</b> , that I last saw the deceased alive on <b>July 2, 1958</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1719 Seminole Rd. Silver Spring, Md.</b> DATE SIGNED <b>July 6, 58</b>			
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>7/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR GROVE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>DORCHESTER, MASS.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Symptoms	
Duration of Illness		Treatment		Result	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Time of Certificate		Place of Certificate	

MADE IN A  
REGISTERED  
OFFICE  
BALTIMORE  
MAY 1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08197

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jersey City</u> 67X-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4712 Rosedale Ave</u>			d. STREET ADDRESS <u>37 Palisade Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Tillie</u> First <u>Stamandrea</u> Middle Last			4. DATE OF DEATH <u>July 20</u> 19 <u>58</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u> NATURALIZED <u>N-84</u>
13. FATHER'S NAME <u>Peter Tropen</u>			14. MOTHER'S MAIDEN NAME <u>Angela De Lio</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes ?</u>		17. INFORMANT <u>Russell Porcino - same as Item 1</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Not Death in Melancholia 30 yrs</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan 20 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>7-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New York Bay Cem.</u>	
22d. LOCATION (City, town, or county) <u>Jersey City, New Jersey</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 1958</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8208

Reg. Dist. No.

08198

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL <b>Silver Spring</b> )		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 3220 Medway St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LeDeau Nursing Home</b>			d. STREET ADDRESS <b>1 SILVER Spring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Volant1 Aaron Saphir</b>			4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-1878</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinest</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Chain Saphir</b>		
14. MOTHER'S MAIDEN NAME <b>Marie Stein</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Nursing Home Record</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>501X</b> IMMEDIATE CAUSE (a) <b>Broncho- pneumonia</b> DUE TO <b>Bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 hrs.</b> (c) <b>4 days</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4912</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>July 5, 1958</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7 - 5 - 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematorium</b>	
22d. LOCATION (City, town, or county) (State) <b>Washington Washington D.C</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home- Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>DA JUL 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Sullivan</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

DECEASED

OLIVER STUBBS

Age 40

1912-12-12

WHITE

Married

Occupation, none



1912

Signature of Medical Examiner

Signature of Medical Examiner

RECORDED AND INDEXED

State Department of Health

7-5-25

See lateral note—Washington D.C.

## 8102 CERTIFICATE OF DEATH

08199

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C. 47x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1110 South Washington St.</b>		d. STREET ADDRESS <b>4000 Mass. Ave. N.W. Apt. 2-3</b>	
3. NAME OF DECEASED (Type or print) <b>Evelyn T. Schweinhaut</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/1900</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>58</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Effie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George O. Schweinhaut</b>		Address <b>same as 2</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>with angina pectoris</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had been under care of Dr. John Evans Washington, DC for</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>above condition</b>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <b>Franklin D. Roosevelt, County Prince Georges</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1958</b> , to <b>July 1, 1958</b> , that I last saw the deceased alive on <b>July 1, 1958</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Corinne Cooper</b>		DATE SIGNED <b>M.D. 104 S Washington St, Rockville, Md.</b>
PHYSICIAN'S NAME (Type)		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7/3/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>July 7 '58</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6024 Berkshire Dr. SAME as right</u>		d. STREET ADDRESS <u>16024 Berkshire Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNE</u> Middle <u>Marie</u> Last <u>Slye</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27 1954</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William F. Slye</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Shukan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> Address <u>16024 Berkshire Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphatic Leukemia</u> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5+ months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 14</u> , 19 <u>58</u> , to <u>July 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>58</u> , and that death occurred at <u>9:45 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>July 21 1958</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Oscar B. Hunter Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Jul 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. In by the funeral director, and completely in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of jury		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury		25. Signature of jury	
26. Signature of jury		27. Signature of jury		28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury		34. Signature of jury		35. Signature of jury	
36. Signature of jury		37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury		49. Signature of jury		50. Signature of jury	
51. Signature of jury		52. Signature of jury		53. Signature of jury		54. Signature of jury		55. Signature of jury	
56. Signature of jury		57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury		65. Signature of jury	
66. Signature of jury		67. Signature of jury		68. Signature of jury		69. Signature of jury		70. Signature of jury	
71. Signature of jury		72. Signature of jury		73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury		85. Signature of jury	
86. Signature of jury		87. Signature of jury		88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury		94. Signature of jury		95. Signature of jury	
96. Signature of jury		97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08201

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>8204 Nolte Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Guy</u> Middle <u>(NMN)</u> Last <u>Smith</u>			<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>4</u> Year <u>1958</u>								
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>7-30-1900</u>		<b>9. AGE</b> (In years last birthday) <u>57</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bar Tender, Elks Club</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Club</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Georgia</u>							
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>TOM R. SMITH</u>							
<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH PRESNELL</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>U.S. Army</u>							
<b>16. SOCIAL SECURITY NO.</b> <u>yes</u>		<b>17. INFORMANT</b> <u>wife Mrs. Mary W. Smith</u> <u>8204 Nolte St., Silver Spring, Md.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>								
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>			<b>22b. DATE THEREOF</b> <u>7/7/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CEMETERY</u>						
<b>22d. LOCATION (City, town, or county)</b> (State) <u>PRINCE GEO. COUNTY, MD.</u>			<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter G. Humphrey</u> <b>ADDRESS</b> <u>SILVER SPRING, MD.</u>								
<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 7 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. G. Humphrey</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8210

## CERTIFICATE OF DEATH

08202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gail (Koss)</b> Middle <b>Tyler</b> Last <b>Somers</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1921</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward F. Koss</b>	
14. MOTHER'S MAIDEN NAME <b>Mary L. Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Bronchopneumonia</b> <b>2049</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive gastrointestinal and urinary tract Hemorrhage</b> DUE TO (c) <b>Acute Myeloblastic Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>days</b> <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 28, 1958</b> , to <b>July 28, 1958</b> , that I last saw the deceased alive on <b>July 28, 1958</b> , and that death occurred at <b>10:20 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur F. Teplitzky</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>7-28-58</b>	
PHYSICIAN'S NAME (Type) <b>Arthur L. Teplitzky, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/30/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 08203

VS A15 (4)  
15M 10/57

222

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G231 7-24-58 et.

## CERTIFICATE OF DEATH

08204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN TB <u>5 years 8 mo.</u>		d. STREET ADDRESS <u>2607-24th St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>SPigel</u> Last <u>SPigel</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1882</u>
9. AGE (In years lost birthday) <u>75?</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Viner</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Wishnick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pt's hosp. Record</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic disease</u> DUE TO <u>hypertension</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia - Rt. side Saphras</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>July 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-16-58</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Eanet</u> M.D.		ADDRESS (Street, city or town, state) <u>6727 16th St. N.W.</u> DATE SIGNED <u>7-16-58</u>	
PHYSICIAN'S NAME (Type) <u>Paul Eanet, M.D.</u>		<u>6727 16th St., N.W.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>July 18, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Canzansky &amp; Sons</u> ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '58</u> REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8094

## CERTIFICATE OF DEATH

08205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>and</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Augustus</u> Last <u>Stansbury</u>				4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/21/79</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>11</u> Min.		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Daily Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. SOLDIERS HOME</u>			
13. FATHER'S NAME <u>Charles Stansbury</u>				14. MOTHER'S MAIDEN NAME <u>Salsburger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hosp records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>526X</u> DUE TO <u>Bronchiectasis chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Simus aneurysm</u> (c) <u>1 year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>July 10, 1958</u> to <u>July 11, 1958</u> , that I last saw the deceased alive on <u>July 10, 1958</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews M.D.</u>				ADDRESS (Street, city or town, state) <u>9601 Colesville Rd Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				DATE SIGNED <u>7-11-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co</u>				ADDRESS <u>Riverside Md</u>		24. REG'D BY REGISTRAR <u>Jul 14 58</u>	
25. REGISTRAR'S SIGNATURE <u>W. W. Chamber</u>				DATE			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8211 CERTIFICATE OF DEATH

Reg. Dist. No. 08206

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		c. LENGTH OF STAY IN 1b <u>47x3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>8 Carver Rd. East</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Steiner</u> Middle <u>2</u> <u>Exile</u>		4. DATE OF DEATH <u>July 16</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 6, 1901</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery County Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Conrad Steiner</u>		14. MOTHER'S MAIDEN NAME <u>Bertrude Kinslow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1941-Triumph</u>	
17. INFORMANT <u>Albert Steiner</u>		Address <u>1941-Triumph</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Bronchial Asthma</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>58</u> , to <u>July 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>58</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph N Dodson MD</u>		DATE SIGNED <u>7/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph N Dodson MD</u>		ADDRESS (Street, city or town, state) <u>2709-P St NW</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elmhurst Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. Green</u>		24a. REC'D BY REGISTRAR <u>Jul 18 58</u>	
ADDRESS <u>1432-Yonkers N.Y.</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Steiner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08207

1. PLACE OF DEATH a. COUNTY <u>Chevy Chase Motors, Wisconsin</u> <u>Ave., Chevy Chase, Bethesda MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Montgomery Co., Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7725 Wisconsin Avenue</u>		d. STREET ADDRESS <u>4824 Park Avenue</u> <u>Chevy Chase, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ALFRED STONE</u>		4. DATE OF DEATH Month Day Year <u>July 25 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 - 4 - 91</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING FIRM</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ALFRED STONE</u>		14. MOTHER'S MAIDEN NAME <u>JANET BURROUGHS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-7471</u>	
17. INFORMANT <u>Police - Bethesda, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary thrombosis</u> (c) <u>Arteriosclerotic coronary artery disease</u> DUE TO stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>902.8</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of back of pick-up truck which ran over his arm</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9:45 a. m. 25 July 1958</u>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chevy Chase Motors</u>		20f. (City or town) (County) (State) <u>Bethesda, Montgomery Co., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J Broschart, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>25 July 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 28 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Dono DeVol</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '58</u>	
ADDRESS <u>2224 - His. av.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

FOR STATE  
HEALTH DEPT

6242  
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: Shaw, George Henry, Wido  
AGE: 40 YEARS  
SEX: Male  
DATE OF DEATH: April 10, 1918

RESIDENCE: 1000 North Street, N. W.  
CITY: Washington, D. C.

CAUSE OF DEATH: Typhoid fever  
MANNER OF DEATH: Natural

DATE OF EXAMINATION: April 10, 1918  
PLACE OF EXAMINATION: At home

SIGNATURE OF EXAMINER: [Signature]  
TITLE: Medical Examiner

DATE OF REPORT: April 10, 1918  
PLACE OF REPORT: Baltimore, Md.

REMARKS: None

TESTS: None

POST-MORTEM: None

EMERGENCY: None

LABORATORY: None

OTHER: None

FILE NO.: 1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oiney</b>	c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b> 13X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. Co. Gen. Hosp.</b>		d. STREET ADDRESS <b>Highland Rd.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sean Francis Sullivan</b>		4. DATE OF DEATH <b>July 28, 1958</b> 19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1957</b>
9. AGE (in years last birthday) <b>1 yrs. 0</b>		10. IF UNDER 24 HRS. Months <b>0</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin B. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Louella Goul</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father</b>		Address <b>Highland Rd. Highland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>929.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b> DUE TO (c) <b>home</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell in tub with 16 in. water in side yard at home.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:45 p.m. 7/28/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Highland Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>JUL 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

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STATE OF  
MISSISSIPPI

DEPT. OF  
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

TIME

HOSPITAL, CLINIC, HOME, ETC.

NAME OF PHYSICIAN

DATE

TIME

PLACE

CAUSE OF DEATH

NOTE

NAME OF PHYSICIAN

APPROVED

SIGNATURE

DEPT. OF HEALTH

ALL IN AND WITH IS IN POWER IN THE VETERAN'S HOME.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

TIME

PLACE

CAUSE OF DEATH

DATE

TIME

PLACE

8214

CERTIFICATE OF DEATH

08209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Aura</u> Middle <u>M.</u> Last <u>SUMNER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William H BREEN</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Lally</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>MRS Edward G. Dreskin</u>		Address <u>Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>150X Pulmonary Edema</u> DUE TO (b) <u>Tracheo Esophageal Fistula</u> DUE TO (c) <u>Carcinoma of Esophagus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3 months</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 July</u> , 19 <u>58</u> , to <u>26 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 July</u> , 19 <u>58</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u>		ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>John C. Murphy</u>		DATE SIGNED <u>7/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8215 CERTIFICATE OF DEATH

Reg. Dist. No.

08210

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Lockville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PHILomena's Rest Home</u>		d. STREET ADDRESS <u>3946 - 2nd St. S.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VALERIA</u> Middle <u>V.</u> Last <u>SWED</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8, 1900</u> 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
13. FATHER'S NAME <u>JOHN RUTKOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>VICTORIA CHMIEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>SVLVAN S. SWED.</u>	
17. INFORMANT <u>SVLVAN S. SWED.</u> Address <u>3946 - 2nd St. S.W.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Muscular Dystrophy</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>unknown</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET OF DEATH <u>1-2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>58</u> , to <u>7-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-16</u> , 19 <u>58</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2205 Richland St. Silver Spring, Md.</u> DATE SIGNED <u>Jul 18 58</u>			
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D. <u>2205 Richland St.</u>		PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>EVERSON, PENN</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Regis A. Balch - 741-11th St. S.E. - Wash. D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 18 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARI LIND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08211

Reg. Dist. No.

8216

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montg.</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Putextant River</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Spencerville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Spencerville</b>		d. STREET ADDRESS <b>Baxton Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Annie Ida Taylor</b>		4. DATE OF DEATH <b>July 8, 1958</b> Month <b>July</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/12</b>
9. AGE (In years and birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm Henry Norris</b>		14. MOTHER'S MAIDEN NAME <b>Ella Quince</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wm Henry Taylor (husband)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by drowning</b> <b>975x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Reported mentally depressed</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>975x</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned self in Putextant R. at Baxton Rd.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Round Oak,</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		24. REC'D BY REGISTRAR DATE <b>JUL 15 '58</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

1915

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES A. HOBBS		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. ST.		JAN 15 1915		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		NONE	
SIGNED		DATE		PLACE		CAUSE		MANNER	
J. A. HOBBS		JAN 15 1915		HOME		HEART DISEASE		NATURAL	
WITNESSED		DATE		PLACE		CAUSE		MANNER	
J. A. HOBBS		JAN 15 1915		HOME		HEART DISEASE		NATURAL	



8217

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Marylander Nursing Home</b>				d. STREET ADDRESS <b>7505 Bybrook Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DELLA</b> Middle <b>CHAPMAN</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> , Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 19, 1868</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Rubin Chapman</b>				14. MOTHER'S MAIDEN NAME <b>Orissa Jane Edwards</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Son</b> <b>William P. Taylor</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154x Carcinoma of rectum, with</b> DUE TO <b>punctate metastases - partial obstruction, 1 year?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>None.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 21</b> , 19 <b>58</b> to <b>July 18</b> , 19 <b>58</b> that I last saw the deceased alive on <b>July 18</b> , 19 <b>58</b> , and that death occurred at <b>3:35 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N. Summit Ave., Bethesda, Md.</b> SIGNED <b>W. A. Linthicum</b> M.D. <b>20d.</b>							
ACTUAL SIGNATURE <b>W. A. Linthicum</b>			PHYSICIAN'S NAME (Type) <b>William A. Linthicum</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. A. Linthicum</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item to File 0231 7-24-58 et

08213

8218

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Golden</b> Last <b>Tipp</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 25, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Samuels</b>		14. MOTHER'S MAIDEN NAME <b>Cecil Erlich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Nervous System Depression</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma to brain</b> DUE TO (c) <b>Carcinoma of breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 min.</b> <b>1 mo.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14</b> , 19 <b>58</b> , to <b>July 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 17</b> , 19 <b>58</b> , and that death occurred at <b>6:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Theodore L. Goodfriend</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>7-18-58</b>	
PHYSICIAN'S NAME (Type) <b>Theodore L. Goodfriend, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 7/19/1958</b>		22b. DATE THEREOF <b>Fort Lincoln Crematory Prince Georges County, Md.</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 21 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IT INFORMATION-BLASS-RO-7000-AND-STATE-OF-MAINE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

118214

8095

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>39 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp</u>			d. STREET ADDRESS <u>1624-Sligo Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Evelyn G.</u> Middle <u>(unnamed)</u> Last <u>Tyler</u>			4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 - '83</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			13. FATHER'S NAME <u>John Galway</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Jane Russell</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>med. records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema and Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis, recent coronary</u> DUE TO (c) <u>Atherosclerosis, generalized</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>1 day</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>July 6, 1958</u> , to <u>July 6, 1958</u> , that I last saw the deceased alive on <u>July 6, 1958</u> , and that death occurred at <u>4:54 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>918 University Blvd., Silver Spring, Md.</u> <u>East</u>					
ACTUAL SIGNATURE <u>Eino Magi</u> M.D. <u>918 University Blvd., Silver Spring, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Eino Magi, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>			ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>
			24b. REGISTRAR'S SIGNATURE <u>Aw. L. Smith</u>		

100

8219

CERTIFICATE OF DEATH

08215

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Virginia</u> Last <u>Tyler</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1899</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>12</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Spotsylvania, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Vincent J. Pokorney</u>				Address <u>Odenton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral edema</u> 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral anoxia</u> DUE TO (c) <u>Cardiac arrest</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Recent surgical procedure, 40% destruction of stomach</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>7-10-58</u> , 19 <u>58</u> , to <u>7-12-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-12-58</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John O. Rollier</u>				ADDRESS (Street, city or town, state) <u>7930 Georgia Ave Silver Spring</u>			
PHYSICIAN'S NAME (Type) <u>John O. Rollier</u>				DATE SIGNED <u>7-12-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burroughs</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>				24. RECEIVED BY REGISTRAR DATE <u>JUL 17 '58</u>			
25. REGISTRAR'S SIGNATURE <u>Ant. ...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08216

8220

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Kingsport</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Anderson Vass</b>		4. DATE OF DEATH Month Day Year <b>July 18, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1912</b>
9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial Trucking</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter T. Vass</b>		14. MOTHER'S MAIDEN NAME <b>Nancy F. Grose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-07-2252</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endocarditis due to Candida parapsilosis</b> DUE TO <b>Rheumatic valvulitis, mitral, old</b> DUE TO <b>Rheumatic fever</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b> <b>Bronchopneumonia</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>June 6, 1958</b> to <b>July 18, 1958</b> , that I last saw the deceased alive on <b>July 18, 1958</b> , and that death occurred at <b>1:47 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 7-18-58</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b> 22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL JULY-21-58</b> 22b. DATE THEREOF <b>JULY 21-58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAKE M. PARK</b> 22d. LOCATION (City, town, or county) (State) <b>KINGS PORT, TENN</b> 23a. REC'D BY REGISTRAR DATE <b>JUL 25 58</b> 23b. REGISTRAR'S SIGNATURE <b>W. O'Dell - P.O. Box</b>			

CERTIFICATE OF DEATH

1920

Box 211, H

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1875		Maryland		123 Main St		Heart Disease		Home		10:30 PM		J. Smith		A. Jones	
Occupation		Married		Single		Widowed		Divorced		Other		Died at		Died of		Died from		Died of		Died from	
Farmer		Yes		No		No		No		No		At home		Natural causes		Accident		Suicide		Other	
Usual Residence		Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death	
123 Main St		Jan 1, 1920		10:30 PM		Home		Heart Disease		Home		10:30 PM		Home		Heart Disease		Home		10:30 PM	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
J. Smith		A. Jones		J. Smith		A. Jones		J. Smith		A. Jones		J. Smith		A. Jones		J. Smith		A. Jones		J. Smith	

# Item 3 Film 235 11-10-58 et 8096 8096 08217 Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> d. STREET ADDRESS <u>7107 Cedar Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Andrew</u> Last <u>Vere</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1958</u>
9. AGE (In years last birthday) yrs. <u>7</u> Months <u>7</u> Days <u>20</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John William Vere</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mothers' record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sclerema neonatorum</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-25-</u> <u>1958</u> , to <u>7-3-</u> <u>1958</u> , that I last saw the deceased alive on <u>7-3-58</u> , <u>19</u> , and that death occurred at <u>7:35a</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>July 6, 1958</u>	<u>Washington Sanitarium &amp; Hosp. Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hays</u> ADDRESS <u>Washington Sanitarium &amp; Hosp.</u>		24a. REC'D BY REGISTRAR <u>JUL 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Cochran</u>

2175263XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
WILLIAM		60		M		W		1880		BALTIMORE		MD		USA		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 10 1940		10:00 AM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL		LABORER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	



8221

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>20 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Ray</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 21, 1956</u>	
9. AGE (In years last birthday) <u>2</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Claude Eugene Ward</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Suddath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Family</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>085.1</u> IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO <u>Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Measles</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 days</u> <u>2 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/12/58</u> to <u>July 12, 1958</u> , that I last saw the deceased alive on <u>7/12/58</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>7/13/58</u>							
ACTUAL SIGNATURE <u>C. H. Ligon, M. D.</u> M.D. <u>  </u>							
PHYSICIAN'S NAME (Type) <u>Dr. C. H. Ligon, M. D., Sandy Spring, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

Small business is the backbone of the U.S. economy. It's the source of 75% of all new jobs created in the U.S. and 60% of all U.S. exports. Small business is the engine of innovation and growth. It's the heart of the American dream.

44. 11/19/1944



CERTIFICATE OF DEATH

DATE

Wesley

ELMIRA FRODIN

DEATH CERTIFICATE

AGE 44 YRS



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City and County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>8 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>124 Johnson Dr. (lincoln Park)</b>			d. STREET ADDRESS <b>124 Johnson Dr. (lincoln Pk.)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Theodore Roosevelt Washington</b>			4. DATE OF DEATH Month <b>7</b> Day <b>15</b> Year <b>58</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6/1911</b>		9. AGE (In years last birthday) <b>47</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Peter Washington</b>			14. MOTHER'S MAIDEN NAME <b>Laura Holley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Allice Washington. Lincoln Park., Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>322.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Alcoholism</b> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Found dead at home</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7/19/58</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park., Rockville, Md.</b>	
22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 23 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>					

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18  
8103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: John Doe  
2. Date of death: Jan 15, 1918  
3. Place of death: Home  
4. Age: 45  
5. Sex: Male  
6. Race: White  
7. Occupation: Teacher  
8. Cause of death: Heart disease  
9. Duration of illness: 2 weeks  
10. Name of attending physician: Dr. J. Smith  
11. Name of medical examiner: Dr. A. Jones  
12. Signature of medical examiner: [Signature]  
13. Date of examination: Jan 16, 1918  
14. Place of examination: Home  
15. Name of witness: John Doe  
16. Signature of witness: [Signature]  
17. Date of witness statement: Jan 16, 1918  
18. Place of witness statement: Home  
19. Name of funeral home: None  
20. Name of undertaker: None  
21. Name of cemetery: None  
22. Name of burial place: None  
23. Name of funeral home: None  
24. Name of undertaker: None  
25. Name of cemetery: None  
26. Name of burial place: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 15 Film G235 11-5-58 et

08221

8223 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>x</u> <u>Kensington</u> Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>		d. STREET ADDRESS <u>5812 Chevy Chase Park</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>4109 Franklin Street</u> way, N.W.	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>S.</u> Middle <u>WATERS</u> Last		4. DATE OF DEATH <u>July 2, 1958</u> Month <u>July</u> Day <u>2</u> Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John D. Snedeker</u> Drew Snedeker		14. MOTHER'S MAIDEN NAME <u>Mary E. Pitts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Elizabeth W. Graeff-Item#2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis,</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced generalised arterio-</u> DUE TO <u>sclerosis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>July 2, 1958</u> , that I last saw the deceased alive on <u>June 30, 1958</u> , and that death occurred at <u>4:30 p.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St Wash 15 D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>July 2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>7/3/58</u>	<u>Cedar Hill Cemetery</u>	<u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alberich</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

8224

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wade</b> Middle <b>Hampton</b> Last <b>WEBB</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 February 1881</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps (Ret.)</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Otto WEBB</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. DAVIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW-II</b>			
17. INFORMANT <b>(Wife) Kathryn Agnes WEBB (Same As #2)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Rt. Coronary Artery</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9 June 1958</b> , 19 <b>58</b> , to <b>3 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2 July</b> , 19 <b>58</b> , and that death occurred at <b>6:25 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 7-3-58</b>							
ACTUAL SIGNATURE <b>G. E. Gorsuch</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>							
PHYSICIAN'S NAME (Type) <b>G. E. GORSUCH, LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. N. Chambers</b>				24a. REC'D BY REGISTRAR <b>JUL 8 '58</b>			
ADDRESS <b>1400 CHAPIN ST. NW WASH. D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>W. N. Chambers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this date has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <u>JOHN J. JONES</u></p>	
<p>AGE: <u>45</u> YEARS</p>	
<p>SEX: <u>MALE</u></p>	
<p>RACE: <u>WHITE</u></p>	
<p>DATE OF DEATH: <u>1945</u></p>	
<p>PLACE OF DEATH: <u>HOME</u></p>	
<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>IMMEDIATE CAUSE: <u>MYOCARDIAL INFARCTION</u></p>	
<p>UNDERLYING CAUSE: <u>ARTERIOSCLEROSIS</u></p>	
<p>DATE OF BIRTH: <u>1900</u></p>	
<p>PLACE OF BIRTH: <u>NEW YORK</u></p>	
<p>EDUCATION: <u>HIGH SCHOOL</u></p>	
<p>OCCUPATION: <u>CLERK</u></p>	
<p>RELIGION: <u>CATHOLIC</u></p>	
<p>DATE OF MARRIAGE: <u>1925</u></p>	
<p>NAME OF SPOUSE: <u>MARY J. JONES</u></p>	
<p>DATE OF INTERMENT: <u>1945</u></p>	
<p>PLACE OF INTERMENT: <u>CATHOLIC CHURCH</u></p>	
<p>SIGNATURE OF PHYSICIAN: <u>JOHN J. JONES</u></p>	
<p>SIGNATURE OF REGISTRAR: <u>JOHN J. JONES</u></p>	

8225

## CERTIFICATE OF DEATH

08223

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Althea Glen Nursing Home</b>		d. STREET ADDRESS <b>Box 366 Defence Highway</b>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude E.</b> Middle <b>Riggles</b> Last <b>Weed</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 2, 1873</b>
9. AGE (In years last birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Richard R. Riggles</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Hoagland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>George Weed Jr</b>		Address <b>Dare Beach Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Recurrent Cerebral Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recurrent Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 June 1958</b> to <b>9 July 1958</b> , that I last saw the deceased alive on <b>8 July 1958</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas P Fogarty</b>		ADDRESS (Street, city or town, state) <b>1011 University Blvd E. Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>Thomas P Fogarty</b>		DATE SIGNED <b>9 July 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Georges Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glennedale, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G232 8-18-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. **08224**

**8226**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>9 Sickles Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Edward</b> Middle <b>Richard</b> Last <b>Weldt</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1914</b>	
9. AGE (In years last birthday) yrs. <b>43</b>		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Edward Weldt</b>				14. MOTHER'S MAIDEN NAME <b>Renee (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>111-10-2027</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IntraCerebral Hemorrhage</b> DUE TO (b) <b>Acute Myelocytic Leukemia</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June 27</b> , 19 <b>58</b> , to <b>July 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>58</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur L. Teplitzky</b> (M.D.)				ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Arthur L. Teplitzky, M. D.</b>				DATE SIGNED <b>7/21/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>7/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Hawthorne, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 22 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>				24c. _____			

MEDICAL CERTIFICATION

50

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2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAINING STATE OF DEATH - BALTIMORE, MD

FILE NO.

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Education		Place of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		1900-01-01		Male		White		Catholic		Married		Teacher		High School		New York		1950-01-01		Heart Disease		Home		10:00 AM		John Doe, M.D.		John Doe, Registrar		John Doe, Informant	
Name of Informant		Relationship		Address		City		State		Zip		Signature		Date		Signature		Date		Signature		Date		Signature		Date		Signature		Date	
John Doe		Son		123 Main St		New York		NY		10001		John Doe		1950-01-01		John Doe		1950-01-01		John Doe		1950-01-01		John Doe		John Doe		John Doe		John Doe	

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

8227

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Westmoreland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Herminie</b> d. STREET ADDRESS <b>Limerick Hill</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Anthony</b> Last <b>WESOLOWSKI</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 2, 1930</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew WESOLOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>Blanche SADOWSKI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes 5-11-48 to DOD</b>		16. SOCIAL SECURITY NO. <b>168 22 2090</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>902.8 premia due to renal shutdown</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>fracture dislocation cervical spine</b> DUE TO (c) <b>3 1/2 hrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dove from dock into 2 1/2' water &amp; struck head on bottom.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>6:20</b> p. m. <b>June 21 1958</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beach</b>	20f. (City or town) (County) (State) <b>Kingsley Beach, Florida</b>
21. I certify that I attended the deceased from <b>June 25</b> , 19 <b>58</b> , to <b>July 12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 12</b> , 19 <b>58</b> , and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Matthew W. Wood MD</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>7-14-58</b>	
PHYSICIAN'S NAME (Type) <b>Matthew W. Wood, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-17-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Westmoreland Memorial Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Westmoreland Co. Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 15 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alberich</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, Medical Examiner for Montgomery County Notified 7-13-58.



8228

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		e. STREET ADDRESS <b>3510 FLORAL STREET</b>	
3. NAME OF DECEASED (Type or print) <b>PEARL</b> First Middle Last <b>LAVINA WHEATE</b>		4. DATE OF DEATH <b>JULY 28 1958</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/24/87</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW J. NICHOLSON</b>		14. MOTHER'S MAIDEN NAME <b>BERDIE HEAD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. James C. Wheate, 3rd, 3510 Floral St. Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>57</b> , to <b>July 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 28</b> , 19 <b>58</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aaron H. Traum</b>		ADDRESS (Street, city or town, state) <b>8237 Georgia Ave Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>AARON H. TRAUM</b>		DATE SIGNED <b>7/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner &amp; Humphrey,</b>		24a. REC'D BY REGISTRAR <b>JUL 30 1958</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08227

8097

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>Forsberg</u> Middle <u>White</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1900</u> 38 yrs.
9. AGE (In years lost birthday) <u>58</u>		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Movie Projectionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Movie Theater</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. White</u>		14. MOTHER'S MAIDEN NAME <u>Cora M. Blanks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Teak from anastomosis of colon</u> (c) <u>Recent surgery</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FEMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 26</u> , 1958, to <u>July 30</u> , 1958, that I last saw the deceased alive on <u>July 30</u> , 1958, and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Eastman</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Colesville Rd. Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. W. EASTMAN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>AUG 4 '58</u>
			24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as life burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08228

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>7811 Exeter Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>L.</u> Last <u>Whiting</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 17, 1942</u>		9. AGE (In years last birthday) <u>15</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>**-----</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. Benjamin Whiting</u>				14. MOTHER'S MAIDEN NAME <u>Betty Forrest</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT (Father) <u>R. Benjamin Whiting</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>821x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Contusions and lacerations</u> DUE TO (c) <u>Fractured skull</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>3 hrs.</u> <u>3 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in motor cycle accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>12:29 AM 7-17-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>Frank J. Broschart M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-17-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Alb...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
2000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Death: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Manner of Death: \_\_\_\_\_

9. Signature of Medical Examiner: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_

11. Signature of Registrar: \_\_\_\_\_

12. Signature of Physician: \_\_\_\_\_

13. Signature of Nurse: \_\_\_\_\_

14. Signature of Pathologist: \_\_\_\_\_

15. Signature of Forensic Scientist: \_\_\_\_\_

16. Signature of Toxicologist: \_\_\_\_\_

17. Signature of Radiologist: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

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98. Signature of Other: \_\_\_\_\_

99. Signature of Other: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808229  
8230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>17 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 WOODMOOR DRIVE</b>		d. STREET ADDRESS <b>15 WOODMOOR DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN H. WARDELL</b> First Middle Last		4. DATE OF DEATH <b>JULY 31 1958</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/94</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUYER -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Millinery</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Linton Wardell</b>		14. MOTHER'S MAIDEN NAME <b>Anne E. Ferguson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-01-3832</b>	
17. INFORMANT <b>Mrs. Dorothy C. Godwin</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7/31/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>8/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WILMINGTON, DELAWARE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wanner B. Pumphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>AUG 1 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Albert</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8231

## CERTIFICATE OF DEATH

08230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Artie</b> Middle <b>only</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 23, 1950</b>	
9. AGE (In years last birthday) yrs. <b>7</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Asa Williams, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Albertha Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency and cardiac arrest</b> DUE TO <b>754.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative complication from correction of Tetralogy of Fallot &amp; atrial septal defect</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>950 X</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>58</b> , to <b>July 16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 16</b> , 19 <b>58</b> , and that death occurred at <b>1:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>7/16/58</b> ACTUAL SIGNATURE <b>N. Perryman Collins</b> M.D. PHYSICIAN'S NAME (Type) <b>N. Perryman Collins, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Columbus</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. N. Horton</b>				24a. REG'D BY REGISTRAR <b>7/28/58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8031

Name of deceased		Sex		Age		Date of death	
John Doe		Male		45		1945	
Place of death		Cause of death		Manner of death		Occupation	
Home		Heart disease		Natural		Farmer	
Residence		Physician		Funeral home		Burial place	
John Doe		Dr. J. Doe		Doe & Sons		Cemetery	
Signature of physician		Signature of funeral director		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]		[Signature]	



## CERTIFICATE OF DEATH

Reg. Dist. No.

08231

8232

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Jervis</b> <b>69x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>152 Pike Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Marcus</b> Middle <b>Stephen</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 30, 1920</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b>29</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
13. FATHER'S NAME <b>Stephen H. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Emily Hendrix</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>090-20-8830</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Amyotrophic Lateral Sclerosis</b> DUE TO (c) <b>Coronary Artery Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 20, 1958</b> , to <b>July 29, 1958</b> , that I last saw the deceased alive on <b>July 29, 1958</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis Gillespie, Jr.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Louis Gillespie, Jr., M.D.</b>		DATE SIGNED <b>7/30/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bethel, New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUL 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a life burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

8233

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 Mo. 3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>253 Evans Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>Lawrence</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-03</b>
9. AGE (In years last birthday) yrs. <b>55</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas Norman WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>Agnes DOUYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>324 96 11</b>	
17. INFORMANT <b>(Wife) Mrs. Lucille G. Williams (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC CARCINOMATOSIS</b> DUE TO (c) <b>ADENOCARCINOMA, BOWEL</b> INTERVAL BETWEEN ONSET AND DEATH <b>72 HRS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 June</b> , 19 <b>58</b> to <b>13 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>13 July</b> , 19 <b>58</b> , and that death occurred at <b>8:00P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Troy</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>7-14-58</b>	
PHYSICIAN'S NAME (Type) <b>John W. Troy, CDR, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>3072 "M" St., N.W. Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>JUL 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital, and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10/2010 10:10:10

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1999

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22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8234

## CERTIFICATE OF DEATH

Reg. Dist. No.

08233

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>24 hrs. 27 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Irene</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1958</u>
9. AGE (In years lost birthday) yrs. <u>24</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Franklin Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Elizabeth Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 1958, to <u>July 3</u> , 1958, that I lost the deceased alive on <u>July 3</u> , 1958, and that death occurred at <u>2:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M. D., Clarksville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel.</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>	

2073192XV2

CERTIFICATE OF DEATH

2234

STATE OF MARYLAND

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G231 7-21-58 et

8235

## CERTIFICATE OF DEATH

08234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>4 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Hammond</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/22/96</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry Wood</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hipkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-34-4784</b>			
17. INFORMANT <b>Alice O. Wood</b>				Address <b>Same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion - Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 - 3 days</b> <b>1 - 2 years</b> <b>2 - 4 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 10 1958</b> , to <b>July 11 1958</b> , that I last saw the deceased alive on <b>July 11 1958</b> , and that death occurred at <b>3:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7/11/58</b>							
ACTUAL SIGNATURE <b>Robert A. Yates</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. A. Yates, M. D.</b>				<b>Olney, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUL 14 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 15

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		1-1-1900		Male		White		Roman Catholic		Married		Farmer		Heart Disease		Home		Jan 10 1950		10:00 AM		J. A. Smith		R. B. Jones		W. C. Brown	
Name of Informant		Relationship		Address		City		State		Zip		Signature		Date		Signature		Date		Signature		Date		Signature		Date	
Jane Doe		Wife		123 Main St		Boston		Mass		02101		J. Doe		Jan 10 1950		J. Doe		Jan 10 1950		J. Doe		Jan 10 1950		J. Doe		Jan 10 1950	

## CERTIFICATE OF DEATH

8236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>				d. STREET ADDRESS <b>2515 13th Street, N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Henry</b> Last <b>Wright, Jr.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 25, 1945</b>	
9. AGE (In years last birthday) <b>13</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George H. Wright, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Norma Sommers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>591X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blood Clotting Defect</b> (c) <b>Nephrotic Syndrome</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 22, 1958</b> , to <b>July 28, 1958</b> , that I last saw the deceased alive on <b>July 28, 1958</b> , and that death occurred at <b>3:25 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis Gillespie, Jr.</b>		M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>7/28/58</b>	
PHYSICIAN'S NAME (Type) <b>Louis Gillespie, Jr.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/31/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Bennett</b>				ADDRESS <b>30 H Street, N.E. Wash; D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Beach</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

## CERTIFICATE OF DEATH

1918

NAME OF DECEASED: [illegible]  
 SEX: [illegible] AGE: [illegible]  
 DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]  
 TIME OF DEATH: [illegible] CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]  
 MEDICAL ATTENDANT: [illegible]

REPORTING PHYSICIAN: [illegible]  
 SIGNATURE: [illegible]

CORONER: [illegible]  
 SIGNATURE: [illegible]

DECEASED'S RESIDENCE: [illegible]  
 STREET: [illegible] CITY: [illegible] STATE: [illegible]

DECEASED'S OCCUPATION: [illegible]  
 EMPLOYER: [illegible]

DECEASED'S MARITAL STATUS: [illegible]  
 SPOUSE'S NAME: [illegible]

DECEASED'S EDUCATION: [illegible]  
 SCHOOL: [illegible]

DECEASED'S RELIGION: [illegible]  
 CHURCH: [illegible]

DECEASED'S RACE: [illegible]  
 COLOR: [illegible]

DECEASED'S SEX: [illegible]  
 SEX: [illegible]

DECEASED'S AGE: [illegible]  
 AGE: [illegible]

DECEASED'S DATE OF BIRTH: [illegible]  
 DATE OF BIRTH: [illegible]

DECEASED'S PLACE OF BIRTH: [illegible]  
 PLACE OF BIRTH: [illegible]

DECEASED'S DATE OF DEATH: [illegible]  
 DATE OF DEATH: [illegible]

DECEASED'S TIME OF DEATH: [illegible]  
 TIME OF DEATH: [illegible]

DECEASED'S CAUSE OF DEATH: [illegible]  
 CAUSE OF DEATH: [illegible]